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ABSTRACT

This document reproduces selected information from the U.S. Department of Education's "Twenty-Second Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act" (2000). These selections consist of text and data tables related to programs for young children with disabilities and their families under the Individuals with Disabilities Education Act (IDEA): the Early Intervention Programs for Infants and Toddlers with Disabilities, Part C of IDEA, which covers services to children from birth through age 2; and the Preschool Program (Section 619) of Part B of IDEA, which covers services to children from ages 3 to 5. Information is provided on the following areas: (1) minority institutions of higher education involved in the preparation of special education personnel; (2) prenatal exposure to alcohol and nicotine; (3) number and percentage of children served by age and disability; (4) educational environments of children served; (5) innovative activities in school programs and services; (6) state improvement and monitoring; (7) estimated resident population for children in different age groups; (8) funding for IDEA and state grants awarded for early intervention and preschool services; (9) number of infants and toddlers served; and (10) early intervention personnel. (Each section contains references.) (CR)

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Programs for Young Children with Disabilities Under IDEA

excerpts from the

Twenty-second Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act
by the U.S. Department of Education (2000)

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January 2001

IDEAs that Work

U.S. Office of Special Education Programs

Preface

This document reproduces selected information from the U.S. Department of Education's *Twenty-second Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act* (2000). These selections consist of text and data tables related to two programs for young children and their families under the Individuals with Disabilities Education Act (IDEA):

- the Early Intervention Program for Infants and Toddlers with Disabilities, Part C of IDEA, which covers services to children from birth through age 2; and
- the Preschool Grants Program (Section 619) of Part B of IDEA, which covers services to children from ages 3 through 5.

These excerpts are reproduced without change along with the actual page number and table designations from the *Report*.

NECTAS compiled this information to provide the primary recipients of our TA services — the coordinators of state Part C and Section 619 programs, the chairs of state interagency coordinating councils, and outreach and demonstration project personnel — and others with easy access to the sections of the *Report* that are most relevant to their work.

The complete *Twenty-second Annual Report to Congress* is available at the Department of Education's Web site at the following URL:

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TO ASSURE THE FREE APPROPRIATE PUBLIC EDUCATION OF ALL CHILDREN WITH DISABILITIES

Individuals with Disabilities Education Act, Section 618

Twenty-second Annual Report to Congress
on the
Implementation of the
Individuals with Disabilities Education Act

U.S. Department of Education

2000

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No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participating in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance, or be so treated on the basis of sex under most education programs or activities receiving Federal assistance.

No otherwise qualified individual with disabilities in the United States shall, solely by reason of his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

Executive Summary

Section I

Context/Environment: This section contains background information on the setting within which special education services are provided to children and youth with disabilities. The first module in this section describes the importance of minority institutions of higher education in the preparation of special education personnel. It also discusses some of the OSEP-sponsored programs at minority institutions that are anticipated to improve the quality of the workforce teaching children and students with disabilities.

The second module discusses prenatal exposure to alcohol and nicotine and its implications for special education. Prevalence of use and effects, service delivery for prenatally exposed children, and OSEP research initiatives are also discussed.

The Importance of Minority Institutions of Higher Education in the Preparation of Special Education Personnel

- The need for personnel who are trained to work with minority students with disabilities is most acute in rural, remote, and urban districts. There is also a high demand for male practitioners.
- The supply of culturally and linguistically diverse related services personnel is not adequate.
- Programs in speech-language pathology or communication disorders are the most prevalent Minority Institution of Higher Education (MIHE) personnel programs in related services.
- MIHE graduates may expedite progress in educating culturally and linguistically diverse students with disabilities and contribute to the development of greater cultural competence among their colleagues. Collectively, they represent 24 percent of the nation's special education personnel preparation programs.

Prenatal Exposure to Alcohol and Nicotine: Implications for Special Education

- Prenatal exposure to alcohol or nicotine can result in significant and far-ranging intellectual, behavioral, and emotional effects and thus have particular implications for special education.
- It is apparent that significant numbers of children prenatally exposed to alcohol and nicotine will require special education and related services.
- OSEP currently funds several research and personnel preparation projects intended to improve results for this population.

SECTION II

Student Characteristics: This section contains five modules related to the characteristics of students served under IDEA and the Federal funding that States receive to serve these students. The modules on infants and toddlers, preschoolers, and students ages 6 through 21 served under IDEA summarize State-reported data. The fourth module describes a special population of children--those with co-occurring disabilities. This module presents a review of the literature, findings from the National Health Interview Survey-Disability Supplement (NHIS-D), and recommendations drawn from the literature. The final module, children with orthopedic impairments, describes this population, provides prevalence data, and discusses special education issues, personnel serving this population, and educational results for these children.

Infants and Toddlers Served Under IDEA

- Comparisons of the children served under Part C with the general population of infants and toddlers by race/ethnicity showed a generally comparable distribution. However, race/ethnicity data were a new component of the 1998 data collection and should be interpreted cautiously.
- States continue to emphasize the home setting as a natural environment in providing services to infants and toddlers with disabilities.

Preschoolers Served Under IDEA

- Over the past 7 years, the number of 3- and 4-year-old children being served grew at a faster rate than that of 5-year-old children, suggesting that children with disabilities are being identified and served at an earlier age.

- Race/ethnicity data suggest that minority enrollment in special education was similar in 1998-99 to the resident population of 3- through 5-year-olds.

- The majority of 3- through 5-year-olds served under IDEA received services in regular education classrooms with their nondisabled peers for 80 percent of the school day.

Students Ages 6 Through 21 Served Under IDEA

- The number of students with disabilities served under IDEA continues to grow at a greater rate than both the resident population and school enrollment. State-reported reasons for this continued increase include better diagnoses and identification.

- In the 6 through 21 age group, Asian and white students were underrepresented in the special education population.

- Black students were overrepresented and Native American students were slightly overrepresented in the special education population.

Meeting the Needs of Students with Co-occurring Disabilities

- One-third of students with disabilities who received special education and related services had co-occurring disabilities. The most common combinations were learning disability and speech/language impairment and learning disability with emotional disturbance.

- Caregivers of children with co-occurring disabilities requested services more often than caregivers whose children had only one disability and were less likely to report that they were satisfied with services provided to their children.

- OSEP is designing or completing a series of child-based studies that may be used to confirm or refute the findings of the NHIS-D related to the prevalence of co-occurring disabilities, demographic factors associated with co-occurring disabilities, services provided to this group of students, and education outcomes.

Students with Orthopedic Impairments

- In 1997-98, 94 percent of students with orthopedic impairments attended schools with their nondisabled peers, and 47 percent of these students received special education and related services outside the regular classroom for less than 21 percent of the school day.

- In 1997-98, 72.4 percent of students ages 17 and older with orthopedic impairments graduated with a diploma. Another 12.8 percent received a certificate of completion. Data also indicate that students with orthopedic impairments have high rates of postsecondary enrollment.

SECTION III

School Programs and Services: The three modules in this section examine some of the programs and services available within schools for children and youth with disabilities and their families. The module on educational settings for students with disabilities presents State-reported data on serving students in least restrictive environments. Applying positive behavioral support (PBS) in schools, the second module, describes the context in which PBS and functional behavioral assessment exist, features of the concepts, and their application to the school environment. The final module in this section, considering assistive and instructional technology for students with disabilities, provides a brief review of how past Federal investments in technology for special education have been instrumental in improving the lives of children with disabilities.

Educational Environments for Students with Disabilities

- Over the past 10 years, the percentage of students with disabilities served in schools and classes with their nondisabled peers has gradually increased.

- The environments in which students receive special education and related services vary by student age and disability. More elementary-aged than secondary-aged students with disabilities are served in schools with their nondisabled peers across all disability categories.

- OSEP currently funds a significant number of grants that target placement issues, primarily inclusion.

Applying Positive Behavioral Support in Schools

- PBS represents an important approach to identifying and organizing effective school practices, especially for students who present significant problem behaviors.

- PBS emphasizes teaching as a central behavior change tool and focuses on replacing coercion with environmental redesign to achieve durable and meaningful change in the behavior of students.

- PBS implementations consider community, family, district, school, classroom, nonclassroom, and individual contexts.

Office of Special Education Programs Technology and Media Services Program: A Focus on Implementation and Utilization

- Beginning in the mid-1980s, OSEP focused resources on programs that would study pertinent issues about the use of technology in achieving educational results for students with disabilities.

- The overarching goals of the OSEP national technology program are: fostering lifelong learning; encouraging participation in diverse educational, domestic, work, and community environments; promoting equity in opportunity for individuals with disabilities; and enabling individuals with disabilities to be productive and independent.

- With OSEP's support, appropriate technology and media continue to be researched, developed, demonstrated, and made available in timely and accessible formats to parents, teachers, and other personnel who provide services to children with disabilities.

SECTION IV

Results: There are three modules in this section. The first module provides a description of the characteristics of children and families entering early intervention. The module on high school graduation presents State-reported data on the graduation rates of students with disabilities by disability and by State. The third module, state improvement and monitoring, discusses OSEP's monitoring system and areas of compliance and noncompliance for both Parts B and C.

Characteristics of Children and Families Entering Early Intervention

- Preliminary data from the National Early Intervention Longitudinal Study (NEILS) indicate that most children are eligible for early intervention because of a developmental delay, and these children are likely to enter early intervention later than children with a diagnosed condition or a risk condition.

- Data also indicate that there are more males in early intervention than are represented in the general birth-through-3 population and that families in early intervention are more likely to be receiving public assistance.

- Future analyses of NEILS data will provide information about the location, amount, and nature of services provided to children with disabilities; types of programs serving young children and their families; and the costs of early intervention relative to the benefits achieved.

High School Graduation

- In 1997-98, 25.5 percent of students ages 17 and older with disabilities graduated from high school with a standard diploma.

- High school graduation rates for students with disabilities vary considerably by disability. Among those least likely to graduate were students with mental retardation, multiple disabilities, and autism.

- The percentage of students with disabilities graduating with a standard diploma varied considerably by State, ranging from a low of 6.8 to a high of 45.4.

- OSEP's efforts to understand factors influencing graduation rates for students with disabilities include funding for a second national longitudinal transition study, which will provide information on associations among high school completion, student characteristics, and educational services.

State Improvement and Monitoring

- OSEP uses research, technical assistance, dissemination, demonstration, systems change, and other strategies to provide State and local early intervention providers and education agencies with tools to assist them in improving results for children with disabilities.

- OSEP's Continuous Improvement Monitoring Process is built around continuity, partnership with stakeholders, State accountability, State self-assessment, data, public process, and the provision of technical assistance.

- In States where there is evidence of substantial compliance with IDEA requirements, OSEP's focus is on the identification and implementation of best practices; in States not demonstrating compliance, OSEP works with the State to develop improvement strategies.

Introduction

The landmark Education for All Handicapped Children Act was passed in 1975 as a reflection of congressional determination that all children with disabilities be offered a free appropriate public education, or FAPE (U.S. Department of Education, 1981). The annual report to Congress on the implementation of IDEA dates back to 1979, when *Progress Toward a Free Appropriate Public Education: A Report to Congress on the Implementation of Public Law 94-142* was published by the U.S. Department of Health, Education and Welfare. By the time the second annual report was published in 1980, the Department of Education had been established and responsibility for the report had passed to that agency.

The primary purpose of the report to Congress has always been to examine progress in the implementation of the nation's special education law. Early reports looked at who was being served under the law and in what settings those services were provided. Those publications included State-reported data in an appendix, a feature that is still seen in today's annual report. However, the body of the report has been organized in a number of different ways over the past 22 years.

The first two annual reports were organized around six questions that constituted the evaluation plan for the Act, with a focus on data and administrative issues (U.S. Department of Education, 1981). The publication of the third annual report in 1981 saw the introduction of a number of lengthy chapters describing the State-reported data, State and local accomplishments and challenges in implementing the Act, and administrative strategies for implementation. Subsequent reports in the 1980s examined the impact of the Act and its implementing regulations (e.g., see U.S. Department of Education, 1983).

The *Sixth Annual Report to Congress*, published in 1984, began to shift the emphasis from the procedures of implementation to the quality of educational programs for children with disabilities (U.S. Department of Education, 1985). This trend continues today. Changes to the annual report have also resulted from changes to the law. For example, the *Ninth Annual Report to Congress* incorporated changes resulting from the EHA Amendments of 1983 (U.S. Department of Education, 1987). Specific changes included a more detailed statistical description of the children receiving services, a description of monitoring activities, and more information on discretionary programs. The ninth annual report was organized around four lengthy chapters based on the four purposes of the Act: to assure that all children with disabilities received a free appropriate public education, to assure that the rights of children with disabilities and their families were protected, to assist State education agencies

(SEAs) and local education agencies (LEAs) in their efforts to provide FAPE to children with disabilities, and to assure the effectiveness of efforts to educate children with disabilities (U.S. Department of Education, 1987).

The report format that was introduced in 1987 was in use for the next 9 years. In addition, the 1992 publication of the fourteenth annual report saw the introduction of a series of papers on special populations of students with disabilities, mandated by the EHA Amendments of 1986. The 1992 report included an appendix on two special populations, migrant students with disabilities and Native Pacific Basin and Native Hawaiian students with disabilities. Limited English proficient students with disabilities were studied as the special populations topic for the fifteenth annual report.

In 1994, the special populations study, this time on Native American students with disabilities, was moved to the main body of the report. The *Seventeenth Annual Report to Congress*, published in 1995, included a special populations report on serving students with disabilities in rural areas, and the eighteenth report looked at the needs of students with disabilities in the inner cities.

The *Nineteenth Annual Report to Congress* introduced a new format based on a conceptual framework that was designed to aid in the understanding of the different factors that affect educational results for students with disabilities. The 1997 report was divided into four sections: Context/Environment, Student Characteristics, Programs and Services, and Results. The issues discussed in the first three sections were envisioned as influencing the results described in the fourth section. Each section contained several individual modules on different topics of interest in the special education field. Taken together, the sections provided an overview of important issues affecting the education of students with disabilities (U.S. Department of Education, 1997).

The first section describes societal and educational forces that have an impact on the education of children with disabilities. The nineteenth annual report included modules on topics such as general education reform, poverty among children, and the disproportionate representation of racial/ethnic minorities in special education. The Student Characteristics section focuses on the population of students receiving services under IDEA, with individual modules on infants and toddlers, preschoolers, and students ages 6 through 21. The nineteenth report also included a module on students with attention deficit/hyperactivity disorder in the Student Characteristics section. The third section looks at school programs and services, and presents data on educational environments, as well as other topics. In the 1997 report, modules on promising classroom interventions, conflict resolution, and the inclusion of students with disabilities in statewide assessments appeared in the Programs and Services

section. Finally, the Results section of the nineteenth annual report highlighted State-reported exiting data and OSEP monitoring efforts and also included a module on the Part H Longitudinal Study. This four-section format is the one in current use for the annual report, and the data-based modules, monitoring module, and State-reported data tables are included in the report each year. Modules are typically written by staff members from OSEP-funded research centers and technical assistance projects and by Westat staff members; the monitoring module is traditionally written by OSEP staff.

The 1998 report was the second to rely on the modular format. The Context/Environment section included an overview of the IDEA Amendments of 1997 and a module on State accountability systems and students with disabilities. In addition to the data-based modules, the Student Characteristics section also presented a paper on gender as a factor in special education, which was the 1997 special populations topic. Under Programs and Services, there were modules on using individualized family service plans (IFSPs) with preschoolers and on national trends in the demand for and shortage of special education teachers. The Results section included papers on standards-based reform and students with disabilities and developing alternate assessments for students with disabilities.

The *Twenty-first Annual Report to Congress*, published in 1999, included modules on parent involvement in educating children with disabilities, developing a highly trained teacher workforce, school discipline and students with disabilities, paraprofessionals in the education workforce, and a special populations study on special education in correctional facilities. Modules in the Results section included an interim report from the National Assessment and a look at progress in implementing IDEA's transition requirements.

This volume of the annual report to Congress, the twenty-second, examines contextual and environmental factors such as the role of minority institutions of higher education in recruiting and training minority educators, and the implications of fetal alcohol and nicotine exposure for special education. In the Student Characteristics section, readers will find modules based on the State-reported data for infants and toddlers, preschoolers, and students ages 6 through 21, as well as papers on students with orthopedic impairments and students with co-occurring disabilities. School Programs and Services looks at positive behavioral interventions and supports, assistive and instructional technologies, and the State-reported educational environments data. In addition to the exiting and monitoring modules, the Results section also includes initial findings from the National Early Intervention Longitudinal Study (NEILS). The *Twenty-second Annual Report to Congress* also includes a special preface reflecting on the progress made in the 25 years since the initial passage of the Education for All Handicapped Children Act. Modules were written by staff from OSEP-funded research, training, and technical assistance projects, as

well as by OSEP staff, outside consultants, and Westat staff. The report was reviewed at multiple levels within the Department of Education. This report was produced by Westat under contract with the U.S. Department of Education and under the direction of the Office of Special Education Programs.

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I. CONTEXT/ENVIRONMENT

The Importance of Minority Institutions of Higher Education in the Preparation of Special Education Personnel

Prenatal Exposure to Alcohol and Nicotine: Implications for Special Education

The Importance of Minority Institutions of Higher Education in the Preparation of Special Education Personnel[1]

The U.S. teaching force is "at a demographic crossroads." From the late 1990s to 2008, more than 2.2 million more teachers will be needed, simply as a result of increasing enrollments and a wave of retirements; long-standing shortages in several subjects and specialties will expand the need, as will attrition (Recruiting New Teachers, Inc., 1999, p. 1). Special education already has a considerable quality shortage (of teachers qualified for their positions) and quantity shortage (of teachers to fill vacancies) (U.S. Department of Education, 1998).

In 1996, 35.8 percent of students enrolled in public elementary and secondary schools were black, Hispanic, Asian/Pacific Islander, or American Indian/Alaskan Native, 12 percent more than in 1976 (National Center for Education Statistics, 1999).[2] The proportion of such students, including new immigrants, continues to increase rapidly (table I-1) but, as reported in 1998, "only 20 percent of undergraduates in teacher education are minority-group members" (Olson & Jerald, 1998, p. 16). By 2009, if trends continue, 40 percent of students but only about 12 percent of the teaching force will be from minority backgrounds (Olson, 2000).

Although ideally all education personnel would be competent to instruct the growing numbers of students from diverse backgrounds, a number of factors impede efforts to provide personnel with the requisite skills and knowledge to work effectively with these students. These factors include lack of consensus on appropriate preparation in this arena; instruction that overviews race, gender, language, and social class in isolation from their relationships to the teaching/learning processes; and a degree of trainee resistance (Artiles & Trent, 1997). Coupled with current and impending shortages and demographic imbalances, this makes it necessary both to recruit culturally/linguistically diverse individuals and to increase the numbers of practitioners who are culturally competent (Ishii-Jordan, 1997). Personnel from minority backgrounds "(a) will enhance the capacity of schools to provide appropriate instruction and will contribute, by their presence and participation, to greater cultural competence among all personnel; (b) will bring essential

[1] This module was developed by the Alliance Project under Grant No. H929T1000F between Peabody College/Vanderbilt University and OSEP, U.S. Department of Education.

[2] The 1996 figures were taken from the Common Core of Data survey and reported in table 46-1 of the *Condition of Education 1999* , by NCES.

Table I-1
Changes in the U.S. Population Under Age 18: 1980-2005

	1980	1990	1995	Projection 2005	Percent Change 1995-2005
White	50,085,021	47,628,229	45,732,900	44,208,100	-3
African American	9,395,912	9,584,415	10,178,500	11,013,000	+8
Hispanic/Latino	5,627,956	7,757,500	9,599,700	12,466,800	+30
Asian/Pacific Islander	1,044,601	2,083,387	2,555,600	3,563,000	+39
Native American	555,735	696,967	673,300	713,000	+6
Other nonwhite	2,673,692	3,611,434	---	---	---

Source: Annie E. Casey Foundation, 1992, 1997.

understandings to the task of restructuring schools where all students can succeed; (and some) (c) will become part of the cadre that completes the doctorate and subsequently influences preservice preparation, where changes must occur so that future teachers will be culturally competent" (Smith-Davis, 2000, p. 2).

Minority institutions of higher education (MIHEs) and other institutions of higher education (IHEs) with substantial minority student enrollments are an important source of these solutions.[3] This chapter presents data on these institutions' programs, overviews selected efforts in some high-demand areas, and summarizes Federal initiatives.

Minority Institutions of Higher Education

The Office of Special Education (OSEP) awards grants for preparation of personnel in minority institutions to IHEs with minority student enrollments of at least 25 percent (U.S. Department of Education, 2000). Historically Black Colleges and Universities (HBCUs), Predominantly Black Institutions (PBIs), Tribal colleges, and Hispanic/Latino-serving institutions are among the IHEs that are eligible to receive these grant awards.

[3] For the purposes of this module, IHEs with minority student enrollments of 25 percent or more will be referred to as MIHEs.

Table I-2
Minority Institutions of Higher Education and Their Preservice Programs

Institution Type	Total MIHEs	Special Education Preparation			Number with Related-Services Programs	Number with >1 Related-Services Program
		Number with Programs	In Number of Jurisdictions[a/]	Largest Clusters		
HBCUs[b/]	104	52	19	NC, TX	32	16
PBIs[c/]	259	12	5	NY	23	7
Hispanic/ Latino	133	16	4	TX	19	8
Tribal	32	12	4	MT, ND, SD, WA	0	0
Asian	52	11	4	CA	11	6
Dual	25	5	3	CA, NY, TX	4	2
Multiple	378	62	17	CA, NY	47	30
Totals	**983**	**170**			**136**	**69**

Notes: a/ The 50 States, the District of Columbia, and Outlying Areas.
b/ Historically Black Colléges and Universities.
c/ Predominantly Black Institutions.

Source: The Alliance Project, 2000.

MIHEs' Preservice Programs in Special Education and Related Services

Table I-2 shows data on MIHEs, by type, with details on those that prepare special educators or paraprofessionals. The right-hand columns add data on MIHE related-services programs in speech-language pathology, audiology, occupational therapy, physical therapy, and school psychology. Gallaudet University, which is designated as an MIHE because its enrollment comprises students with disabilities, is not included.

Eight States have no MIHEs: Idaho, Maine, New Hampshire, Oregon, Rhode Island, Utah, Vermont, and Wyoming. Thirteen others have none that prepare special education teachers: Alaska, Arizona, Colorado, Connecticut, Indiana, Kansas, Kentucky, Massachusetts, Minnesota, Nebraska, Nevada, Wisconsin, and West Virginia.

Preparation for High-Demand Positions

Demand for special education personnel involves general personnel shortages and deployment barriers, as well as the need for personnel with particular competencies. The need for personnel who are trained to work with minority students with disabilities is most acute in rural, remote, and urban districts. Across geographic settings, however, there are striking needs for special educators and related-service personnel who are qualified to work with minority students. There is also a high demand for male practitioners. OSEP grants to MIHEs have been supporting various efforts to meet these needs, a few of which are profiled in this section. (Unless otherwise indicated, abstracts of OSEP personnel preparation grants are the source of project summaries in this section. Recent abstracts are also published in Orkwis, DeCarme, & Glover, 1998.)

Rural and Remote Areas

Isolation makes recruitment and retention a substantial problem for many rural and remote districts, particularly for Bureau of Indian Affairs schools and Tribal schools (Pavel, Curtin, Christenson, & Rudes, 1995). In addressing these shortages, it appears more effective to provide a Tribal member with teacher training than to teach the Tribal culture and, in some cases, language to an outsider (U.S. Department of Education, 1994). Moreover, career ladders, uses of technology, and regional support groups show promise of improving the supply of personnel in remote districts (National Association of State Directors of Special Education, 1996). The 13 OSEP personnel preparation grants awarded to Tribal colleges since 1992 have incorporated one or more of these strategies. For example:

A consortium of Tribal colleges in North Dakota received an OSEP grant for an associate degree program for paraprofessionals. The project joined Cankdeska Cikana Community College, as fiscal agent, with Turtle Mountain Community College and Fort Berthold Community College. Minot State University, which is not an MIHE, acted as a subcontractor. Curricula were examined, new courses were developed where necessary, and faculty have mentored and consulted with new course instructors. The colleges had already integrated cultural elements into their overall curricula, and these have been extended to special education training. Fort Berthold hired faculty who lived in the remote sites where teacher aides are already working, so that college courses can be offered at their work sites (Green, 2000).

Career ladder programming is a feature of Fort Peck Community College's comprehensive effort to improve education on its Montana reservation. Since 1995, Fort Peck has offered special education professional development to Native Americans on the reservation to encourage opportunities to earn degrees and to

employ more Native American special educators and paraprofessionals in the reservation's schools. In 1997, the college started its special education program for teacher aides and substitutes, and, in 1998, it finalized an agreement with Montana State University-Billings for delivery of the endorsement program in special education. The Tribal Education Department provides incentives for Tribal members, including monetary awards for milestones, such as high school diploma, GED, and 1-year certificates (Belvin, 1999).

Distance learning technologies are used by Montana's Little Big Horn College to deliver special education training for aides at a remote reservation site. Little Big Horn also trains paraprofessionals on campus and coordinates distance learning from Montana State University-Billings, which awards bachelor's and master's degrees in special education to those who complete the program. In all, 24 Native Americans have recently completed training at one of these three levels (Belvin, 1999).

Urban/Inner City Schools

Approximately 43 percent of cultural or language minority public school students live in urban areas, and "most of them attend schools in which more than half the students are poor and that are predominantly, often completely, minority" (Edwards, 1998, p. 6). Urban districts have difficulty filling vacancies, especially in undersupplied fields (Olson & Jerald, 1998), are twice as likely as others to hire teachers who hold emergency license or no license (Edwards, 1998), and have high rates of disengagement and attrition among teachers (Van Horn, 1999). In addition, "high turnover in urban districts, where many of the older, more experienced African American teachers are concentrated, will necessitate hiring from a pool of new teachers that is increasingly white" (Murnane et al., 1991, as cited in U.S. Department of Education, 1996, pp. 95-96). Various MIHEs are endeavoring to improve these conditions.

Full qualifications and career ladders. Coppin State College in Maryland trains annual cohorts of 65 long-term substitutes, provisionally certified teachers, teachers in surplus disciplines, and teacher aides for special education positions in the Baltimore City Public Schools. Personnel are trained with concentrations in mild/moderate disabilities, severe disabilities, or speech and hearing. The improved curriculum is relevant to special education for a predominantly inner-city population of African Americans and smaller numbers of other minority students.

Victims of substance abuse. At Hampton University in Virginia, minority students receive training to provide speech, language, and hearing services for infants, toddlers, and preschool children, with a special focus on children affected by

substance abuse and on African American children in inner cities. The project supports seven graduate students per year over 4 years.

Incarcerated youth. Hunter College, City University of New York is preparing 30 individuals to educate incarcerated minority youth who have emotional and behavioral disorders. Because New York City area correctional facilities are seriously deficient in teachers trained to work with disabled juvenile offenders, this project is expected to have a decisive impact.

Technologies for delivery of training. The goal of DIALS (Distance Instruction for All Learners) is to increase the number of inner city and rural special educators who are qualified in high-incidence disabilities. Developed by a partnership of three University of South Florida campuses and a consortium of school districts, DIALS uses synchronous two-way interactive video and audio in real time, with remote-site mentors and Internet and email support. Many participants are from minority populations and/or are working in high-poverty areas.

Doctoral concentration. Preparing Urban Leaders in Special Education (PULSE) at the University of San Francisco provides doctoral preparation in research and college teaching, with an emphasis on urban, multicultural special education and recruitment of candidates from diverse and bilingual populations. Up to 12 individuals are expected to complete the doctorate, and 10 are expected to earn master's degrees in teaching culturally diverse children with mild/moderate disabilities.

Linguistic Diversity

Between 1990 and 1997, "the number of students with limited English proficiency (LEP) . . . increased by an estimated 57 percent--to approximately 3.5 million. These children are among the most educationally disadvantaged of all populations" (Johnson & Vanderlinde, 1999, p. 1). "About one-third of school-age Hispanics are new immigrants, a demographic group that typically does not do well in school" (Blair, 2000, p. 6). Linguistic diversity is increasing as a result of immigration. Some large districts have students from more than 150 countries of origin who speak 130 or more languages and dialects; many small districts are also experiencing the impact of immigration (Smith-Davis, 1999). The need for personnel who speak the languages of LEP students is clear. Equally important are personnel who can distinguish between language limitations and disabilities in working with students who have limited proficiency in English.

About 80 percent of districts report "some" to "a lot of" difficulty recruiting bilingual teachers, and 53 percent report difficulties in recruiting English-as-a-second language (ESL) teachers (Johnson & Vanderlinde, 1999). Since it is still more difficult to hire special education personnel with these linguistic competencies, affected districts must often rely on bilingual aides to mediate instruction in languages that other personnel do not understand (Smith-Davis, 1999). Although relatively few IHEs have programs in linguistic diversity, MIHEs are fairly well represented.

Cross-cultural special education. Loyola Marymount University in California has expanded its Cross-Cultural Special Education Program for greater emphasis on urban education in a service area that includes 80 language groups. The project is preparing 60 candidates to educate LEP and bilingual students with disabilities, a large proportion of whom are minority students.

Trainees of Haitian origin. The University of Miami has enrolled 38 students, mainly from the Haitian community, to complete a master's program in both early childhood special education and teaching ESL. Since only one early childhood special education teacher in Dade County is a primary speaker of Haitian Creole, there is a great demand for these graduates.

Linguistic diversity and hearing impairment. New Mexico State University offers interdisciplinary master's degree preparation for racially and linguistically diverse trainees in the education of students with deafness and hearing impairments and with an emphasis on bilingual education and ESL. Recruitment is conducted in cooperation with IHEs in New Mexico and South Texas. The goal is to improve the supply of personnel to work with the Southwest's tricultural/trilingual population.

Master teachers with cultural/linguistic competence. The University of Texas-El Paso trains master teachers to assist diagnosticians and school psychologists in differentiating between disabilities and cultural/linguistic differences and in identifying LEP children who have special needs. Thirty educators from nine local districts and two Apache reservations are enrolled in the program. Summer institutes near the Apache reservations and in El Paso provide experience in teaching strategies that are effective with specific cultural and language characteristics, as well as those that are generally useful with diverse children.

Doctoral preparation. Over a 5-year period at California State University-Fresno, 15 Spanish-speaking and/or culturally diverse participants are expected to receive a doctorate in educational leadership, and 22 are expected to earn master's degrees, both with a specialization in minority special education. Collaboration involves four University of California campuses, local school districts, and the California Department of Education.

Related Services

The supply of culturally and linguistically diverse related-services personnel is not adequate. For example, only 7.3 percent of members of the American Speech-Language-Hearing Association (ASHA) are from minority backgrounds (ASHA, 1998, as cited by Guillory, in press) while, at the same time, the numbers of minority-group members with speech and language problems are increasing (Guillory, in press). Among members of the National Association of School Psychologists (NASP), 8 percent are from minority populations (NASP, 1999). Programs in speech-language pathology or communication disorders are the most prevalent MIHE preservice programs in related services, but school psychology, occupational and physical therapy, and other disciplines are also represented.

Communication disorders and cultural/linguistic diversity. At Louisiana's Southern University, Project Access addresses the underrepresentation of speech pathologists and audiologists competent to work with culturally diverse children and youth. Undergraduate and graduate programs emphasize recruitment of students from underrepresented groups, particularly African Americans. Up to 8 undergraduate and 16 master's students are expected to complete this program (Guillory, in press). The University of the District of Columbia prepares Spanish/English bilingual trainees to become speech-language pathologists to serve Hispanic infants, toddlers, children, and youth. The curriculum includes courses and practica on bilingualism, language acquisition in bilingual children, and assessment and treatment of bilingual and LEP students. At Howard University in the District of Columbia, preservice speech-language pathologists learn to provide quality services for minority nonspeaking children who use augmentative and alternative communication (AAC) and are developing literacy skills. Eighteen individuals are gaining competencies in the range of AAC services, with emphasis on literacy acquisition and development of culturally diverse children and youth.

School psychology. The Multicultural/Cross-Cultural School Psychology Project at San Diego State University supports the preparation of 39 school psychology trainees to work with ethnolinguistically diverse students with disabilities and their families and teachers. The project has revised the school psychology program and created new partnerships with school districts.

School counselors. At Florida International University, culturally and linguistically diverse graduate students in school counseling gain competencies for working with students who have disabilities. Each year, 10 trainees enter the specialization track in exceptional student education of the master's program in school counseling, which emphasizes collaboration among students, faculty, families, schools, and the community, as well as clinical field experiences in culturally diverse urban schools.

Male Practitioners

Among the most distressing shortages is the declining proportion of males in the teaching force. For example, African American males comprise only 0.4 percent of elementary special education teachers and 2.2 percent at the secondary level (Townsend, Thomas, Witty, & Lee, as cited by Voltz, 1998). Absence of males of all races is a particular loss for economically disadvantaged children in inner cities, many of whom need positive male role models in their lives.

Male-targeted projects. The University of South Florida's Chrysalis Project is collaborating with county agencies to train, support, and provide teaching positions for African American, Hispanic, and white men to teach urban children with disabilities. Over a 3-year period, 60 males will be enrolled. Bethune Cookman College in Florida prepares African American men to teach and serve as role models for preschoolers with disabilities. The training model emphasizes competencies in providing culturally and linguistically relevant education to young children with disabilities.

Partnerships

Partnerships between MIHEs and other institutions, local education agencies, and State education agencies (SEAs) are enabling factors in capacity building, and many MIHE's have been creating and extending these connections. Partnerships of selected institutions have been mentioned in the foregoing profiles. Others are described below.

MIHE and non-MIHE partnership. Tuskegee University in Alabama has formed a partnership with Auburn University to prepare students from minority backgrounds for special education and for faculty teaching exchanges. Through this agreement, Auburn also recruits Tuskegee University graduates to enroll in its advanced preparation programs.

MIHE school district partnerships. In partnership with three urban, multi-ethnic districts, Kean College of New Jersey is developing a collaborative model for successful identification, recruitment, retention, and preparation of culturally and linguistically diverse trainees for special education careers. North Carolina Central University is increasing the number of licensed special educators in emotional/behavioral disabilities, including those from minority populations. The program is based on a model for providing school-wide services to racially and culturally diverse students who have emotional/behavioral disabilities that was developed in partnership with the Wright School Re-Ed Center and Durham Public Schools. The

partnership includes development of demonstration programs in five Durham schools. At South Carolina State University, the Department of Educational Administration and Special Education Program have joined with public schools in South Carolina, North Carolina, and Georgia to increase the number of minority school leaders in rural areas with minority populations and to improve the multicultural competencies of currently employed administrators. Fifteen participants of each type are recruited annually (Monteith, in press).

Although many more examples of institutional cooperation and public school partnerships could be cited, it generally appears that MIHEs' relationships with SEAs are neither as numerous nor as strong. Interest and cooperation by the National Association of State Directors of Special Education shows promise of incorporating the talents of MIHE faculty members, and the values of their personnel preparation programs, into comprehensive systems of personnel development, planning and implementation of State Improvement Grants, and other initiatives of greater numbers of SEAs in the future.

Federal Initiatives

The role of MIHEs in preparing personnel for special education has been enhanced by efforts of MIHE faculty members and administrators and by the stimulus from OSEP. OSEP originated a priority on "preparation of personnel for minority handicapped children" in fiscal 1987. Although the terminology of the priority has changed over time, and is now the Minority Institutions priority, its intent has been to advance the preparation of greater numbers of qualified personnel from historically underrepresented populations. The current Minority Institutions priority encompasses all categories of personnel preparation at all degree levels, but MIHEs are able to submit applications under any other OSEP personnel preparation priority for which postsecondary institutions are eligible.

The IDEA Amendments of 1990 (Public Law 101-476) required the Secretary of Education to develop and implement a plan to provide outreach services to minority entities to assist them in participating more fully in the discretionary programs under the Act (Section 610(j)). Under a subsequent OSEP priority to implement this requirement, the first grant for the Alliance Project was awarded in 1991 for the purpose of supporting MIHE efforts to participate more fully in OSEP's personnel preparation program. This intent of Public Law 101-476 was restated in the 1997 amendments (Public Law 105-17). Section 661(d)(2) of the 1997 amendments emphasized the role of HBCUs and other MIHEs in improving results for students with disabilities. The Alliance Project's current cycle is scheduled to continue until 2002.

The Alliance Project provides grant-writing workshops, individual mentoring, seminars, other professional development activities, and information services to MIHEs that prepare special education teachers, administrators, and related-services personnel or have underpinnings to initiate or expand such offerings. Between 1992 and 1999, 1,253 faculty members from 261 MIHEs participated in Alliance activities.

Collectively, MIHEs represent 24 percent of the nation's special education personnel preparation programs. In 1991, 19.6 percent of OSEP's personnel preparation projects were located at MIHEs (176 of a total of 897 projects). In 1999, 30.6 percent of OSEP's projects were located at MIHEs (184 of a total of 602). MIHE grants have increasingly been awarded not only under the Minority Institutions priority but also in response to all of OSEP's other personnel preparation priorities (Alliance Project, 1999). The level of MIHE participation in OSEP-funded personnel preparation is a promising indicator of OSEP and MIHE efforts to improve results for children with disabilities.

Conclusion

MIHEs' programs in special education and related services are serving their communities and States well, and some are providing personnel and/or training models at the regional and national level. Many of these programs use innovative and successful practices for recruiting, retaining, preparing, and inspiring trainees to make a difference in the lives of children. MIHE graduates may aid progress in educating culturally and linguistically diverse students with disabilities and contribute to the development of greater cultural competence among their colleagues. Some alumni are already having a positive impact on the preparation of future personnel and on local, State, and national policy. Colleagues in other preservice programs, local districts, and SEAs can learn from the MIHE experience and can benefit through new relationships with MIHEs to advance the education of students with disabilities in America's valuable multicultural communities.

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Prenatal Exposure to Alcohol and Nicotine: Implications for Special Education

In the past decade, a great deal of media attention has been focused on women who use illicit drugs during pregnancy; this has been particularly true of crack cocaine. However, research suggests that rates of alcohol and tobacco use during pregnancy are far higher than those of cocaine or other illegal drugs (e.g., see Brady, Posner, Lang, & Rosati, 1994; Mathias, 1995; Slotkin, 1998). The literature on maternal alcohol and tobacco use during pregnancy clearly delineates the harmful effects these substances may have on the developing fetus and on the child's subsequent academic, behavioral, social, and emotional development. Accordingly, this module will focus on the substantial body of research regarding prenatal exposure to alcohol and nicotine and on the implications of such exposure for special education.

Prenatal substance exposure has proven to be a complicated issue for researchers and educators alike. For a number of reasons, it is often difficult to determine whether a child has been prenatally exposed to alcohol, nicotine, illegal drugs, or a combination of these substances. For example, women may underreport their use of alcohol and other substances during pregnancy (Ventura, Martin, Curtin, & Mathews, 1997), and there is no single biological marker for fetal exposure to alcohol (Bagheri, Burd, Martsolf, & Klug, 1998; Wekselman, Spiering, Hetteberg, Kenner, & Flandermeyer, 1995). In addition, there is evidence that the effects of prenatal alcohol exposure on infants are underrecognized by physicians, even among infants born to women with a history of alcohol abuse. Stoler and Holmes (1999) note that this underrecognition may be due to doctors' reluctance to label women as substance users or to a lack of training in making such diagnoses. In many instances, it is also difficult to separate the effects of a single substance such as alcohol from those of polydrug use, which may include tobacco and illegal drugs (Brady et al., 1994), or from other prenatal conditions that may increase the negative effects of prenatal exposure to alcohol, such as maternal undernutrition (Abel, 1998) or lack of prenatal care (Day, Cottreau, & Richardson, 1993). Finally, it is difficult to separate the effects of prenatal exposure to a given substance from the effects of a child's postnatal environment (Brady et al., 1994; Roebuck, Mattson, & Riley, 1999; Weinberg, 1997).

Prenatal Exposure to Alcohol

A report on a joint project of the U.S. Department of Health and Human Services and the U.S. Department of Education notes that "although prenatal [illicit] drug exposure has captured a great deal of public attention, prenatal exposure to alcohol is

more widespread and has perhaps an even more serious impact" (Brady et al., 1994, p. 1). Research on the level of alcohol exposure needed to cause significant impairment has yielded varying results, but the U.S. Centers for Disease Control and Prevention (CDC) note that "even low to moderate alcohol use has been shown to negatively impact birth outcome, independent of other risk factors" (Ventura et al., 1997, p. 12). There is no known safe level of alcohol consumption during pregnancy (Bagheri et al., 1998; Bauer, 1999). It has been estimated that more than 2.6 million infants are prenatally exposed to alcohol each year in the United States (Gomby & Shiono, 1991). This section of the module reviews a number of large studies that have attempted to estimate the national prevalence of alcohol exposure during pregnancy.

Prevalence of Alcohol Use During Pregnancy

Brady and her colleagues (1994) note that prevalence studies of maternal drinking during pregnancy are subject to a number of limitations. Most hospitals lack protocols for screening pregnant women for alcohol and drug use. Where protocols do exist, they tend to rely on pregnant women's self-reports regarding their alcohol and drug use. Such protocols are of limited use because women are reluctant to admit using alcohol or drugs during pregnancy. In addition to the problems posed by self-report, relatively few researchers have used population-based samples (Mayes, Bornstein, & Zuckerman, as cited in Brady et al., 1994). The studies reported here have generally been population-based and have relied on self-reported data.

The 1988 National Maternal and Infant Health Survey (NMIHS) studied 9,953 women who had given birth to a live infant in 1988. Overall, 45.4 percent of respondents reported drinking alcohol during the 3 months prior to learning they were pregnant, and 20.7 percent reported continuing to drink after learning they were pregnant. In addition, 16.8 percent reported having three or fewer drinks per month during pregnancy, and 0.6 percent reported that they consumed six or more drinks per week during pregnancy (CDC, 1995).

Respondents who reported drinking at any time during pregnancy were categorized as "prenatal drinkers," while those who reported consuming six or more drinks per week during pregnancy were categorized as "frequent drinkers." The likelihood of drinking during pregnancy increased directly with age and was highest among white, non-Hispanic women. In addition, likelihood of prenatal drinking was higher among women with 16 or more years of education and those with annual household incomes of $40,000 or more. Prenatal drinking was reported by 38.2 percent of women who smoked more than 10 cigarettes per day, compared with 17.2 percent of women who were nonsmokers. In contrast, "frequent drinking" was more likely among women age 35 or older, those who were members of racial/ethnic minority

groups, and those whose household incomes were $10,000 or less. The likelihood of frequent drinking increased as smoking levels increased and was more than three times higher among women who received no prenatal care than among those who did receive prenatal care (CDC, 1995).

Floyd, Decoufle, and Hungerford (1999) used the 1988 NMIHS data set to study women's reported alcohol use during the 3 months prior to learning they were pregnant. Overall, 45 percent of participants reported drinking during that period, and 5 percent reported consuming six or more drinks per week. In addition, 60 percent of the women who drank reported that they did not learn they were pregnant until after the fourth week of gestation. Once participants realized they were pregnant, many of them stopped drinking altogether; those who continued to drink reported significant reductions in the amount of alcohol they consumed. For example, prior to pregnancy recognition, 56 percent of the women who used alcohol reported consuming less than one drink per week; after pregnancy recognition, 81 percent of drinkers fell into this category. Five percent of all women reported having six or more drinks per week prior to pregnancy recognition, but fewer than 1 percent continued to drink at this level after realizing they were pregnant. Overall, alcohol use dropped from a prevalence rate of 45 percent during the 3 months prior to pregnancy recognition to 21 percent following pregnancy recognition (Floyd et al., 1999). These findings suggest that drinking during the earliest stages of pregnancy is more common than drinking after pregnancy recognition. Since half of all pregnancies in the United States are unplanned (Forrest, as cited in CDC, 1997), the NMIHS data raise questions about the number of women who consume moderate or even heavy amounts of alcohol during the early stages of an unrecognized pregnancy.

More recently, the National Institute on Drug Abuse (NIDA) studied 2,613 women who gave birth in 1992 for the National Pregnancy and Health Survey and found that 18.8 percent of participants consumed alcohol at some point during their pregnancy. Nearly 23 percent of white women reported drinking during pregnancy, compared with 15.8 percent of African American women and 8.7 percent of Hispanic women (Mathias, 1995).

The CDC compared 1991 and 1995 data from the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing, State-based, random-dialed telephone survey of the U.S. population, to determine trends in the prevalence of alcohol use during pregnancy. In 1995, 33,585 women between the ages of 18 and 44 were interviewed by telephone about their alcohol consumption during the previous month; 1,053 respondents, or 4.7 percent, reported being pregnant at the time of the interview. Pregnant women who reported consuming at least one alcoholic drink during the preceding month were categorized as "any drinking," and those who

reported consuming an average of seven or more drinks per week or five or more drinks on at least one occasion were classed as "frequent drinking" (CDC, 1997).

In 1995, 16.3 percent of pregnant women reported "any drinking" during the previous month, compared with 12.4 percent in 1991. "Frequent drinking" was approximately four times more common in 1995 than in 1991 (3.5 percent versus 0.8 percent). This difference in the rate of frequent drinking persisted after the researchers controlled for age, race, household income, marital status, employment status, education level, and smoking status (CDC, 1997).

It should be noted that many of the studies described above relied on self-reported data that may be subject to both recall and reporting bias. Despite these limitations, researchers have learned a great deal about alcohol consumption during pregnancy. Studies examining data collected over the past 12 years have suggested that anywhere from 16.3 percent to 45.4 percent of women drink alcohol during pregnancy (CDC, 1995, 1997). In the latter study, 20.7 percent of women reported that they continued to drink after learning they were pregnant. Variation in reported rates of maternal drinking does not obscure the fact that a significant number of infants are prenatally exposed to alcohol each year. The next section of this module examines the potential effects of alcohol on the developing fetus, with a particular focus on the implications of such exposure for the field of special education.

Effects of Alcohol Use During Pregnancy

It is well-documented that alcohol is teratogenic, or toxic, to a developing fetus, and the effects of maternal alcohol consumption during pregnancy are "potentially devastating" (Wekselman et al., 1995, p. 296). Possible consequences of alcohol consumption during pregnancy include physical birth defects, cognitive or learning problems, attention deficits, behavioral and emotional problems, growth retardation, and the triad of anomalies that comprise fetal alcohol syndrome (FAS). Specific abnormalities are linked to alcohol use at particular times during pregnancy (National Institute on Alcohol Abuse and Alcoholism (NIAAA), 1997). For example, physical birth defects are more likely when alcohol is used during the first trimester, while growth restriction is associated with alcohol use late in pregnancy (Bauer, 1999).

Fetal Alcohol Syndrome and Fetal Alcohol Effects

In 1973, two University of Washington researchers described a condition marked by the co-occurrence of three primary characteristics: growth deficiency, a distinctive pattern of abnormalities primarily observable in the face, and central nervous system (CNS) dysfunction. The researchers named this condition fetal alcohol syndrome

(Streissguth et al., 1997). Children who manifest some but not all of the characteristics of FAS, and who were exposed prenatally to alcohol, may be referred to as exhibiting fetal alcohol effects (FAE). FAEs represent the "partial or incomplete expression of alcohol's teratogenic influence on the developing fetus" (Bauer, 1999, p. 97). The full spectrum of characteristics resulting from fetal alcohol exposure may also be referred to as alcohol-related neurodevelopmental disorders (ARND) (Institute of Medicine, 1996). The characteristics associated with fetal alcohol exposure are most often observed along a continuum ranging from milder effects to full fetal alcohol syndrome (NIAAA, 1997).

A 1996 Institute of Medicine report estimates the incidence of full FAS at 0.5 to 3 births per 1,000, with higher rates in some populations. Among heavy drinkers, the rate of FAS occurrence has been placed at 4.3 percent (Abel, 1998). If FAEs are considered, the incidence is much greater. A recent study concluded that the incidence of FAS and other alcohol-related neurodevelopmental disabilities reached almost 1 in 100 live births (Sampson et al., as cited in Streissguth, Barr, Bookstein, Sampson, & Olson, 1999). In the United States, the incidence of FAS is higher among African Americans and American Indians (CDC, 1996; NIAAA, 1994), in lower socioeconomic classes (NIAAA, 1994), and among women who have previously given birth to a child with FAS (NIAAA, 1997).

Cognitive impairment is one characteristic of FAS. FAS is the leading known cause of mental retardation in the United States (Bagheri et al., 1998; Streissguth et al., 1999; Weinberg, 1997). Among all the major causes of mental retardation, FAS alone is completely preventable (Bauer, 1999). In addition to cognitive deficits, FAS and FAE are associated with a number of secondary conditions that are related to fetal alcohol exposure. Streissguth and her colleagues (1997) sought to determine the prevalence and range of these conditions in persons diagnosed with FAS or FAE.[1] The researchers defined primary conditions as "functional deficits that reflect the central nervous system (CNS) dysfunctions inherent in the FAS or FAE diagnosis" (i.e., those that result directly from the teratogenic effects of alcohol on the developing fetus), while secondary conditions were defined as "those that arise after birth and presumably could be ameliorated through better understanding and appropriate interventions" (p. 27). Primary conditions were measured through the use of intelligence, achievement, and adaptive behavior tests; secondary conditions were assessed using a life history questionnaire.

[1] Streissguth and her colleagues (1997) referred to these conditions as "primary and secondary disabilities." To avoid confusion with the term "disabilities" as defined under IDEA, the word "conditions" is used here instead.

Primary Conditions

Of the 473 participants who were assessed for primary conditions, 178 had a diagnosis of FAS, and 295 had a diagnosis of FAE.

The 178 participants with a FAS diagnosis had an average IQ of 79 and an average adaptive behavior score standard score of 61.[2] On the achievement tests, the average reading score was 78, the average spelling score was 75, and the average mathematics score was 70. The 295 participants with a FAE diagnosis had an average IQ of 90, with a VABS score of 67. Their achievement test scores averaged 84 on reading, 81 on spelling, and 76 on mathematics.

Secondary Conditions

Secondary conditions related to fetal alcohol exposure were assessed in 415 participants with FAS or FAE who ranged in age from 6 to 51. Six main secondary conditions were studied (see figure I-1):

- *Mental health problems*, defined as having any one of a list of mental health problems or as ever having gone to a psychotherapist or counselor for a mental health problem.
- *Disrupted school experience*, defined as having been suspended or expelled from school or having dropped out of school.
- *Trouble with the law* was defined as ever having been in trouble with the authorities, charged, or convicted of a crime.
- *Confinement*, including inpatient treatment for mental health, alcohol, or drug problems, or ever having been incarcerated for a crime.
- *Inappropriate sexual behavior* was defined as having had repeated problems with one or more of 10 inappropriate sexual behaviors or ever having been sentenced to a sexual offenders' treatment program.
- *Alcohol/drug problems* was defined as having ever been in treatment for an alcohol or drug problem or as having an alcohol or drug problem.

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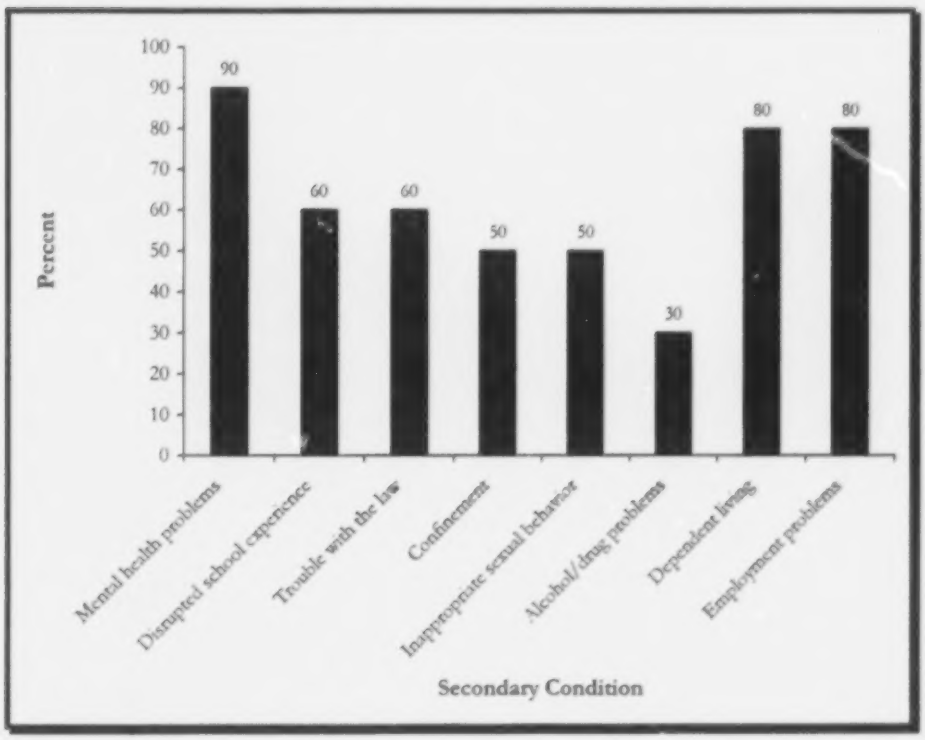
[2] Participants were given an age-appropriate IQ test and the Wide Range Achievement Test-Revised (WRAT-R). The Vineland Adaptive Behavior Scale (VABS) was administered to a caregiver or other person who knew the participant well. For both IQ and adaptive behavior, a score of 100 is normal.

Figure I-1
Secondary Conditions Among Persons with FAS or FAE



Note: N = 415.

Source: Streissguth et al., 1997.

Male participants had higher rates of disrupted school experience, trouble with the law, and confinement than did female participants. Rates of other secondary conditions generally did not differ significantly by sex (Streissguth et al., 1997).

Finally, to determine how many persons with FAS or FAE were living independent lives as adults, the researchers evaluated two additional secondary conditions for the 90 participants who were 21 or older. Eighty-three percent of those participants were in dependent living situations, and 79 percent reported problems with employment. Only 7 of the 90 participants age 21 or older were living independently and did not have employment problems (Streissguth et al., 1997).

An important finding of this study was that although participants with FAE had less cognitive impairment than those with FAS, they actually had more secondary

conditions related to fetal alcohol exposure than did the FAS group. The authors suggest that this difference is partly due to the fact that the FAE group tended to be diagnosed later than the participants who had FAS; early diagnosis appeared to protect participants against the development of secondary conditions. Overall, the authors found that "people with FAS and FAE have an unacceptable level of secondary [conditions] that severely impairs their quality of life and is extremely costly to society" (Streissguth et al., 1997, p. 38).

Weinberg (1997) recommended systematic study of the prevalence of persons with FAS and FAE in specialized settings. The findings of Streissguth and her colleagues (1997) suggested that disproportionate numbers of alcohol-affected individuals have problems with the law. Accordingly, Fast, Conry, and Loock (1999) studied the prevalence of FAS and FAE among youth between the ages of 12 and 18 who had pleaded guilty to or been found guilty of committing a criminal offense and had subsequently been remanded for a forensic psychiatric/psychological assessment. Of the 287 young people remanded for evaluation, 67 (23.3 percent) had an alcohol-related diagnosis. The majority (n = 64) were diagnosed with FAE, and three had a diagnosis of FAS. In this sample, the occurrence of FAS was 3 to 10 times the accepted worldwide rate, which the authors cite as 1 to 3 per 1,000 births; the occurrence of FAE was 10 to 40 times the accepted worldwide incidence. The researchers noted that only 3 of the 67 youth with an alcohol-related diagnosis had received such a diagnosis prior to this special assessment, which resulted from an encounter with the juvenile justice system (Fast et al., 1999).

Other Effects of Prenatal Alcohol Exposure

FAS represents the most extreme end of a spectrum of negative effects resulting from prenatal exposure to alcohol (Stoler & Holmes, 1999). The NIAAA reports that "outcome is a function of prenatal dose" (1997, p. 9). Carmichael Olson and her colleagues (1997) note that "effects of lower levels ('doses') of alcohol exposure most often emerge as problems in behavior and adaptive function" (p. 1187). For example, a team of researchers from San Diego State University found that children who were prenatally exposed to alcohol are likely to exhibit many psychosocial and behavioral problems, even if they do not meet criteria for a diagnosis of FAS (Roebuck et al., 1999).

Similarly, in their long-term follow-up study of a birth cohort of approximately 500 children through age 14,[3] Streissguth and her colleagues (1999) found attention, memory, and information processing deficits in the alcohol-exposed children that

[3] The cohort was composed of children whose mothers reported a range of prenatal drinking patterns, including abstention.

persisted over time. In addition, the researchers reported antisocial and delinquent behaviors, as well as difficulties with classroom learning and behaviors, from school age through age 14. Using the same sample, Carmichael Olson et al. (1997) found a correlation between greater reported prenatal alcohol use and increased behavior and learning difficulties during early adolescence. In addition, two maternal drinking patterns--"binge" drinking and alcohol exposure early in pregnancy--were associated with greater risk of adolescent behavior and learning problems.

Over the past 25 years, a substantial body of multidisciplinary research has emerged to suggest that prenatal alcohol exposure can have significant physical, behavioral, intellectual, and emotional effects. Many of these effects, particularly mental retardation and behavioral and social deficits such as poor judgment, impulsivity, hyperactivity, and poor social skills, manifest themselves in the classroom and may involve the provision of special education and related services (Thompson & Thompson, 1998).

Prenatal Exposure to Nicotine

"The effect of cigarette exposure on the developing fetus may be the most underrated, at least in public opinion," Eyler and Behnke (1999) note. Tobacco is used worldwide by people of all socioeconomic classes; it is perhaps for this reason that "tobacco use prenatally does not receive the press that crack smoking does" (p. 108). This section of the module discusses prevalence studies of maternal smoking during pregnancy and describes the effects of prenatal nicotine exposure.

Prevalence of Tobacco Use During Pregnancy

The same caveats that apply to prevalence studies of maternal drinking during pregnancy must also be considered in relation to studies of tobacco use. Relatively few studies have attempted to determine the prevalence of this behavior. NIDA's 1992 National Pregnancy and Health Survey reported that 20.4 percent of women smoked during pregnancy. Tobacco use was reported by 24.4 percent of white participants, compared with 19.8 percent of African American women and 5.8 percent of Hispanic women (Mathias, 1995).

Table I-3
Percentage of Women Who Smoked During Pregnancy by Race, Hispanic Origin, and Age

Race/Hispanic Origin	Mother's Age								
	< 15	15-17	18-19	20-24	25-29	30-34	35-39	40-49	All Ages
Hispanic	3.3	4.5	4.8	4.5	3.8	4.2	5.0	4.0	4.3
White, non-Hispanic	21.5	27.3	28.6	23.9	14.8	12.0	12.4	10.6	17.1
Black, non-Hispanic	2.4	4.3	5.9	8.8	12.6	16.2	18.2	14.8	10.6

Notes: Data collected from birth certificates in 46 States, the District of Columbia, and New York City in 1995, and analyzed by CDC/NCHS.

Source: Ventura et al., 1997.

A CDC analysis of data reported on the birth certificates of the 3.9 million births that occurred in 1995 found that smoking during pregnancy was reported by 13.9 percent of women giving birth that year.[4] Patterns of tobacco use during pregnancy differed by race and ethnicity, with non-Hispanic white women ages 18-19 years having the highest rate (29 percent). Under the age of 30, smoking rates were considerably higher for non-Hispanic white women than for non-Hispanic black or Hispanic women. However, smoking rates for women age 30 or older were highest for non-Hispanic black women. Hispanic women, regardless of age, had consistently low smoking rates of 3 percent to 5 percent (Ventura et al., 1997). Table I-3 illustrates differences in smoking rates by race, Hispanic origin, and age.

Other publications have noted higher smoking rates; for example, Slotkin (1998) reported that 25 percent of all pregnant women in the United States who smoke continue to smoke after they learn they are pregnant. National Center for Health Statistics data cited in Chomitz, Cheung, and Lieberman (1995) suggest that 20 to 25 percent of American women smoke during pregnancy. The U.S. Department of Health and Human Services (DHHS, 1990) reported that about one-quarter of women who smoke prior to pregnancy stop smoking when they learn they are pregnant; another third reduce their smoking level upon learning they are pregnant. However, as Eyler and Behnke (1999) note, "Most women who smoke have difficulty and rarely accomplish abstaining from tobacco use throughout pregnancy" (p. 108).

[4] In 1995, tobacco use during pregnancy was reported on birth certificates in 46 States, the District of Columbia, and New York City, comprising 80 percent of U.S. births during the year.

Effects of Tobacco Use During Pregnancy

A number of studies related to prenatal alcohol or illegal drug exposure have used maternal smoking as a covariate and reported significant results related to smoking. Animal studies have also demonstrated the teratogenic effects of nicotine (Slotkin, 1998). It is difficult to separate the effects of prenatal exposure from those of postnatal exposure to secondhand smoke, since, as Eyler and Behnke (1999) state, "It is likely that, when born to a smoking mother, a child will also be reared within a home filled with smoke" (p. 108). Nonetheless, research does suggest that a number of adverse effects are associated with prenatal exposure to nicotine.

Low birth weight, a condition that is responsible for approximately half of all infant deaths, is a characteristic of prenatal nicotine exposure (Bauer, 1999). Chomitz and her colleagues (1995) note that approximately one-fifth of all low birth weight cases could be prevented if women did not smoke during pregnancy. In 1995, 12.2 percent of infants born to women who smoked during pregnancy weighed less than 2,500 grams (5 lb. 8 oz.), compared with 6.8 percent of births to nonsmokers. The risk of low birth weight associated with maternal smoking increases with maternal age. Among women age 30 and older, the low birth weight rate for births to women who smoked was at least 2.3 times that for births to nonsmokers. The risk of low birth weight also increases with the number of cigarettes smoked (Ventura et al., 1997). Other possible physical effects of maternal smoking during pregnancy include preterm delivery (Kramer, 1991), perinatal mortality (Slotkin, 1998), increased risk of Sudden Infant Death Syndrome (Schoendorf & Kiely, 1992), and childhood asthma (Weitzman, Gortmaker, Walker, & Sobol, 1990).

Aside from these physical problems, children whose mothers smoke during pregnancy may also develop a number of learning and behavioral problems, many of which may not appear until childhood and adolescence (Slotkin, 1998). For example, Wakschlag and her colleagues (1997) conducted a 6-year longitudinal study on the relationship between maternal smoking during pregnancy and conduct disorder. Participants included 177 boys who were ages 7 to 12 at the time of the first assessment. The researchers found that women who smoked were significantly more likely to have a child with conduct disorder than women who did not smoke during pregnancy. Subsequent logistic regression analyses found that smoking more than half a pack of cigarettes daily during pregnancy remained a significant predictor of conduct disorder even after controlling for socioeconomic status, parental psychopathology, other pregnancy risk factors, and parenting risk factors.

Milberger and her colleagues have published two studies examining a hypothesized link between maternal smoking during pregnancy and attention deficit hyperactivity disorder (ADHD). The first study compared 140 children with a diagnosis of

ADHD to 120 children without an attention deficit diagnosis. All participants were white, non-Hispanic boys between the ages of 6 and 17. Twenty-two percent of the boys with ADHD had a history of maternal smoking during pregnancy, compared with 8 percent of the control group. The correlation remained statistically significant after controlling for socioeconomic status, maternal IQ, maternal ADHD, paternal IQ, and paternal ADHD (Milberger, Biederman, Faraone, Chen, & Jones, 1996).

In the second study, Milberger and her colleagues sought to determine whether the association between ADHD and maternal smoking in pregnancy previously seen in boys with ADHD would hold true for their high-risk siblings[5]. The researchers compared high-risk siblings with siblings of a non-ADHD control group. Fifty-one percent of the siblings in this study were boys (n = 158), 57 percent were siblings of children with ADHD (n = 171), and 13 percent had ADHD themselves (n = 38). The researchers found that 47 percent of the high-risk siblings with ADHD had a history of maternal smoking during pregnancy (n = 15), compared with 24 percent of the siblings without ADHD (n = 33). This relationship remained significant after controlling for socioeconomic status, parental IQ, and parental ADHD (Milberger, Biederman, Faraone, & Jones, 1998).

The effects of prenatal nicotine exposure on long-term cognitive development are still unclear. Lassen and Oei (1998) reviewed 16 longitudinal studies that looked at the cognitive effects of prenatal nicotine exposure. Twelve of those studies reported significant cognitive deficiencies in children whose mothers smoked during pregnancy. Of the four studies that found no significant cognitive deficits, the pattern of results "reflected subtle deficits in the intellectual function of children associated with maternal smoking during pregnancy" (p. 650). The authors concluded that the long-term effects of prenatal smoking on children's intellectual functioning are difficult to isolate because the majority of studies to date have not controlled for the postnatal effects of passive smoking.

The studies summarized above describe a number of physical and behavioral effects that result from tobacco use during pregnancy. These effects, together with those related to maternal alcohol use during pregnancy, may pose challenges for regular and special educators alike. The next section of this module describes some of the research on service delivery for prenatally exposed children and discusses barriers to effective service provision.

[5] In this study, siblings of children with ADHD were referred to as "high risk" because they have been shown to be at high risk for ADHD, comorbid psychiatric disorders, and cognitive impairments (Milberger et al., 1998).

Effective Service Delivery for Prenatally Exposed Children

Sinclair (1998) notes that "each [prenatally exposed] child must be assessed and educated with particular attention to his or her individual strengths and vulnerabilities" (p. 125). Individualized assessment is one of the practices that practitioners have found helpful in working with exposed children.

Although there is no "typical profile" of a prenatally exposed child, researchers have described several specific behaviors and psychosocial impairments frequently exhibited by these children in the classroom, including:

- difficulty forming attachments,
- impulsivity,
- impaired social skills,
- extremes of classroom aggression or introversion,
- inability to handle multiple stimuli, and
- inability to recognize verbal cues (Sinclair, 1998; Sluder, Kinnison & Cates, 1996/1997).

These special needs and behaviors suggest a number of particular classroom practices that may be useful. For example, researchers have determined that these children need a small, individual workspace that remains unchanged from day to day (Meyer & Morris, 1994; Sluder et al. 1996/1997). Adherence to a routine is also important for many children (Thompson & Thompson, 1998). Smooth transitions between activities allow children to stay focused and reduce the likelihood of extreme mood and behavior swings; thus, practitioners suggest announcing that an activity will end in a specific amount of time so that the children are prepared for the change (Sluder et al., 1996/1997; Thompson & Thompson, 1998).

OSEP Research Initiatives

In response to the challenges of providing effective special education services to prenatally exposed children, the Office of Special Education Programs (OSEP) currently funds several research and personnel preparation projects intended to improve results for this population. Researchers at the University of Kansas, the University of Minnesota, and the University of South Dakota are collaborating on a longitudinal study of the early elementary school experiences and developmental

outcomes of children prenatally exposed to alcohol and drugs. The researchers hypothesized that the effects of prenatal exposure are compounded by environmental risk factors. Accordingly, the study has focused on five such factors: poverty, limited parental education, large family size, minority status, and single parent status. Initial analyses have confirmed that exposure to a greater number of environmental risk factors has increasingly negative effects on developmental age and growth rate. Results from the study will be incorporated into preservice training in graduate coursework and disseminated through publications and conference presentations.

Another OSEP-funded project will provide master's-level preparation to 48 students to serve infants and toddlers with low-incidence disabilities, including FAS, in rural Alaska. The 36-credit, competency-based program will include a two-course distance learning sequence; a summer intensive clinical course and practicum; a six-semester clinical study in autism, FAS/FAE, and severe disabilities; and leadership activities in the areas of care coordination, consultation, and in-service training.

The Alaska Early Childhood High Incidence Master's Training Program will prepare rural special educators and related services personnel to serve children ages 3 through 6 with disabilities and their families. The program will recruit rural underrepresented Alaskan natives and train 48 students, plus an additional 16 who will graduate after the grant period ends, with the skills necessary to provide effective early childhood services. An intensive clinical study and practicum in FAS and FAE is a major component of the program.

In addition to these research efforts, OSEP funded the National Early Childhood Technical Assistance System (NECTAS) through a cooperative agreement to produce and distribute a publication entitled *Resources Related to Children and Their Families Affected by Alcohol and Other Drugs* (3rd Edition). This publication includes national training and information resources, state programs and agencies, and Federal and private funding sources and is available from NECTAS (http://www.nectas.unc.edu/pubs/pubslist2.html#resor).

Department of Education Participation in Other Federal Initiatives

A representative of the Office of Special Education and Rehabilitative Services (OSERS) serves as the chairperson of a Fetal Alcohol Syndrome/Alcohol-Related Neurodevelopmental Disorders (FAS/ARND) Work Group. The purpose of this group is to improve educational interventions and services for children ages birth through 8 with FAS/ARND and their families. The work group reports to the Federal Interagency Coordinating Council and the Interagency Coordinating

Committee on Fetal Alcohol Syndrome (ICCFAS) of the NIAAA and the National Institutes of Health (NIH).

The goals of the FAS/ARND Work Group include the following:

- develop methods for the early screening, referral and diagnosis of children with FAS/ARND;
- clarify the ethical and confidentiality issues involved with screening and assessment in schools and early intervention settings;
- identify and refine appropriate intervention strategies to effectively serve children with FAS/ARND and their families and to prevent secondary conditions related to fetal alcohol exposure; and
- collaborate to provide intensive, effective, and on-going training and technical assistance.

The work group comprises representatives from a number of Federal agencies, including NIAAA, the Department of Education, the CDC, NIH, the Substance Abuse and Mental Health Services Administration, Head Start, the Bureau of Indian Affairs, the Indian Health Service, and the Office of Juvenile Justice and Delinquency Prevention. It also includes parents, educational practitioners from the field, and representatives of different advocacy and health groups. Medical and research personnel from the University of Washington, Emory University School of Medicine, and UCLA Neuropsychiatric Institute and Hospital are also members of the work group.

In addition to chairing the FAS/ARND Work Group, OSERS has appointed a representative to the ICCFAS. This committee coordinates the efforts of government agencies to address FAS, FAE, ARND, and alcohol-related birth defects. Its mission is to facilitate communication and cooperation among the different disciplines and organizations that address the health, education, developmental disabilities, and social service issues related to these disorders.

Summary

Although the deleterious effects of both alcohol and nicotine on developing fetuses have long been recognized and documented, high numbers of children continue to be prenatally exposed to alcohol and nicotine--often before their mothers realize they are pregnant. Prenatal exposure to both of these legal substances can result in

significant and far-ranging intellectual, behavioral, and emotional effects and thus have particular implications for special education. A 1996 Institute of Medicine report on FAS pointed out the need for research related to early identification and concomitant early intervention services and to the provision of special education and related services. Although it is unclear how many children are prenatally exposed to alcohol and nicotine each year, it is apparent that significant numbers of these children will continue to require special education and related services. Further efforts are necessary in order to better understand the prevalence and scope of the problem, to develop improved assessment and identification methods, and to determine the most effective academic and behavioral interventions for this population of students.

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II. STUDENT CHARACTERISTICS

Infants and Toddlers Served Under IDEA

Preschoolers Served Under IDEA

Students Ages 6 Through 21 Served Under IDEA

Meeting the Needs of Students with Co-occurring Disabilities

Students with Orthopedic Impairments

Infants and Toddlers Served Under IDEA[1]

In 1986, the Infants and Toddlers Program was added as Part H of the Individuals with Disabilities Education Act (IDEA), with the goal of encouraging development or expansion of statewide early intervention services for children ages birth through 2 with disabilities and their families. By September 30, 1994, all States had ensured full implementation of Part H. Under the reauthorization of IDEA, the IDEA Amendments of 1997, Part H was renamed Part C.

The Number of Children Served Under IDEA, Part C

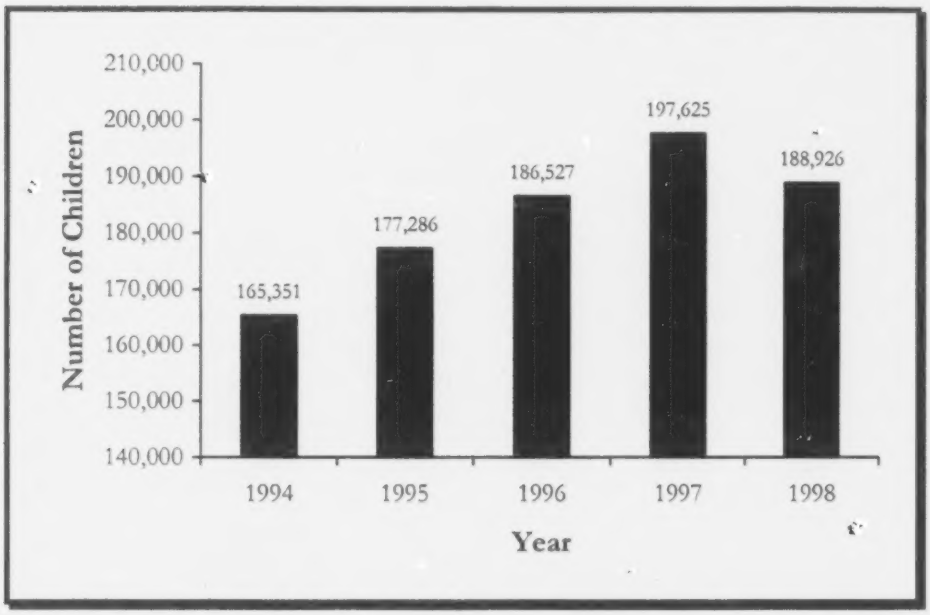
It is most useful to evaluate the number of children served under Part C of IDEA beginning with the data reported in December 1994 because it was in this fiscal year that all States reported that they had fully implemented Part C (see figure II-1). In 1994, 165,351 children were reported served under Part C. By 1997, 197,625 infants and toddlers were reported as receiving services. Anecdotal reports from the States attributed this steady increase to better child-find efforts and more efficient tracking and reporting methods. Surprisingly, however, the number of children served under Part C has declined since 1997: In 1998, the number of children reported as receiving services under Part C decreased by 4.4 percent, to 188,926. Two States, Ohio and Illinois, accounted for 82.4 percent of the decline. These two States reported changes in administrative data collection procedures that may provide some explanation for the change.

In 1997, Ohio reported 22,917 infants and toddlers served under Part C, compared with 5,161 in 1998 (see table AH1). The State reported that this decrease resulted from the use of a new data collection system, Early Track, that was first implemented in 1998. Ohio's data managers believe that this system is more reliable and will eliminate potential duplication of child count that may have contributed to the higher counts reported in the past. The State expects data collection to improve as personnel become more familiar with the new tracking system.

Illinois reported a less striking but still significantly lower number of children served in 1998: The 1997 figure of 7,758 dropped to 4,849 in 1998. Illinois noted that this decrease was likely the result of a change in the Part C lead agency; responsibility for Part C passed from the Department of Education to the Department of Human

[1] This annual report includes child count data for 1998-99 and non-child count data for 1997-98.

Figure II-1
Number of Infants and Toddlers Served Under IDEA, Part C,
1994 Through 1998



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Services in January 1998. A change in lead agency can affect child count data, as different agencies often have different counting systems and different priorities. Together, Ohio and Illinois reported serving 20,665 fewer children under Part C in 1998 than in 1997. Finally, Puerto Rico reported serving 4,773 children in 1997 and 2,592 in 1998 a decline of 2,181. Puerto Rico did not provide an explanation for the decline.

In contrast, 20 States and Outlying Areas reported minimal or no declines in their 1998 Part C child counts, and 36 States and Outlying Areas reported increases. The most significant increases were reported by California (16,696 in 1997 to 19,421 in 1998) and New York (17,950 in 1997 to 20,592 in 1998). Texas also reported a significant increase, serving 12,877 children in 1998 and 11,861 in 1997. Reasons for increases in the number of infants and toddlers served under Part C varied. For instance, Kentucky attributed its increase in the number of children served in 1998 to a more accurate count as a result of its new electronic counting system and general growth in the system. South Dakota noted that its increase was the result of increased child find efforts, an explanation given by a number of States.

The IDEA Amendments of 1997 encouraged all States to develop methods of identifying, evaluating, and serving at-risk children. This was also the first year that States which report that they serve at-risk children were required to separately report the number of at-risk children served. Currently, eight States and one Outlying Area serve at-risk populations under Part C (California, Guam, Hawaii, Indiana, Massachusetts, New Hampshire, New Mexico, North Carolina, and West Virginia).[2] Although the criteria for defining an at-risk child vary by State, in general, an at-risk child is one who would be at risk of experiencing a substantial developmental delay if early intervention services are not provided. According to the *Part C Data Dictionary*, States may consider prominent biological and environmental factors that can have a derogatory effect on development, including low birth weight, respiratory difficulties in newborns, infection, malnutrition, and a history of abuse and neglect (Westat, 2000).

Of the States that serve at-risk children, two reported more than half of their Part C population in that category. California reported 13,737 children at risk, or 70.7 percent of its Part C population, and Hawaii reported 1,976 children at risk, or 63.4 percent of its Part C population. The other States that serve these children reported much smaller proportions of their Part C children as being at risk (see table AH2).

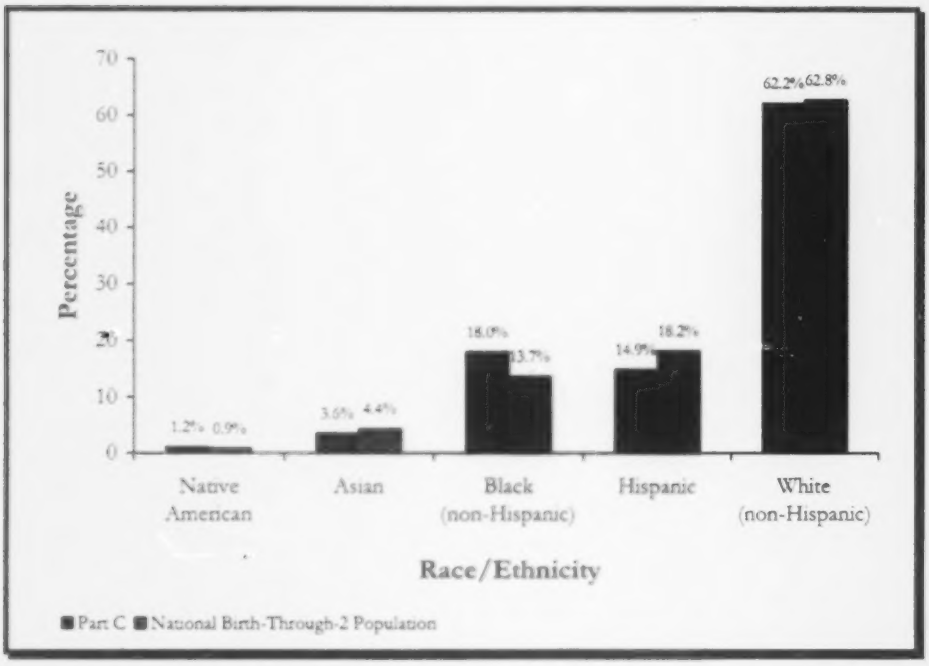
Race/Ethnicity of Infants and Toddlers Served

A new component of the 1998 child count for all programs under IDEA was the collection of race/ethnicity data. This collection is intended to provide more information on the issue of potential minority overrepresentation among children receiving special education services. Since race/ethnicity was a new component of the 1998 data collection, the race/ethnicity data should be interpreted cautiously. Comparisons of the children served under Part C with the general population of infants and toddlers by race/ethnicity are shown in figure II-2.[3] The racial/ethnic distribution was generally comparable for the two groups. It was reported that 62.2 percent of the children served under Part C were white (non-Hispanic), compared with 62.8 percent of the birth-through-2 population nationally. Eighteen percent of the children served under Part C were black (non-Hispanic), compared with the national figure of 13.7 percent. The Hispanic population accounted for 14.9 percent of the children served under Part C vs. 18.2 percent of birth through 2-year-olds

[2] Two States--Massachusetts and New Mexico--did not separately report the number of at-risk infants and toddlers served on the data form.

[3] Census figures, which are included in DANS, are from July 1998 estimates by the U.S. Bureau of the Census.

Figure II-2
Race/Ethnicity: National Versus Part C Percentages



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

nationally.[4] Asian children comprised 3.6 percent of the children served under Part C vs. 4.4 percent nationwide. Finally, 1.2 percent of the children served under Part C were American Indian, which was comparable to the national average of 0.9 percent for birth through 2-year-olds (see tables AH3 and AF6).

Also reported on the basis of race/ethnicity were data describing the at-risk populations of the States and Outlying Areas that serve them. Of the eight States that serve at-risk children under Part C, six reported race/ethnicity data for those children. The racial/ethnic population of California's at-risk population was comparable to all infants and toddlers served under Part C in that State. In both cases, the percentage of Hispanics served under Part C, whether as at risk (13.2 percent) or under the general Part C criteria (12.0), was double the percentage of

[4] For this analysis, we excluded the infants and toddlers served in Puerto Rico and the Outlying Areas. Puerto Rico classified its children as nearly 100 percent Hispanic. Including those children increases the percentage of Hispanic children served under Part C of IDEA to 16.2 percent.

Hispanics in California's resident population (5.6 percent). In Indiana, the percentage of at-risk children served in each race/ethnicity category was comparable to both the general Part C and resident populations. The racial/ethnic composition of the at-risk children in North Carolina was almost identical to the general Part C service population. In both these populations, the percentage of black infants and toddlers served (40.0 percent) was greater than in the general population (23.9 percent), while the percentage of white children (52.0 percent in the Part C population) was less than the general population (68.2 percent). Hawaii reported a slightly higher percentage of its Asian population served to be at risk (89.7 percent) than that which was represented in its total Part C population (83.9 percent) or the general population (64.6 percent). Hawaii reported only half the percentage of white, non-Hispanic children as at risk (5.8 percent vs. 10.7 percent of the total Part C population). New Hampshire reported higher numbers of American Indian and Hispanic children as being at risk than occurred in the population: American Indians comprised 0.8 percent of New Hampshire's Part C population, but 5.3 percent of the State's at-risk population, and Hispanics comprised 1.9 percent of New Hampshire's Part C population, but 10.5 percent of the at-risk population. Finally, West Virginia reported a higher percentage of black (non-Hispanic) children at risk (6.5 percent) than that of the total Part C population (1.8 percent) (see table AH3).

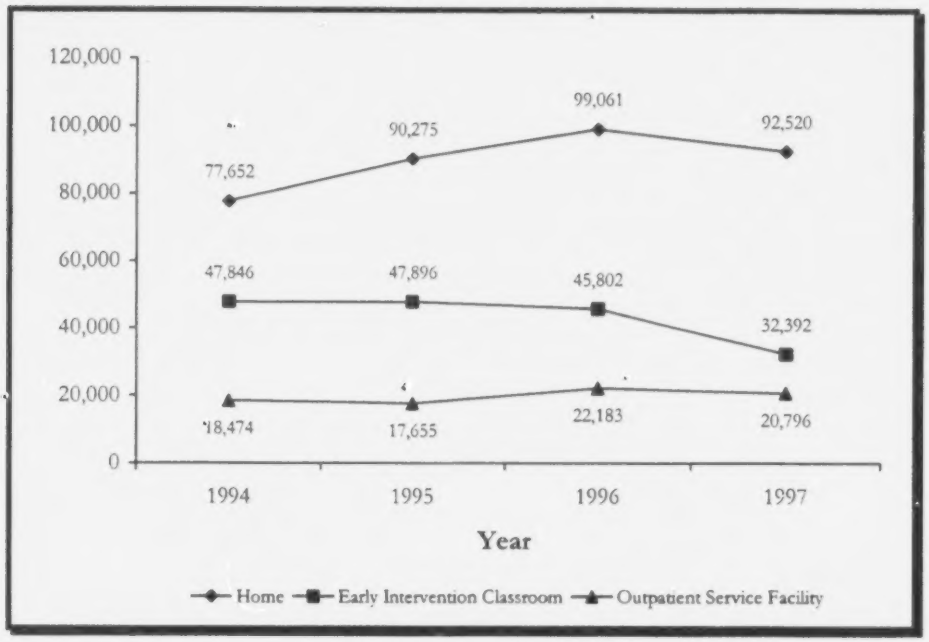
Early Intervention Service Settings for Infants and Toddlers with Disabilities

Since 1990, birth through 2-year-olds with disabilities have been served in one of the following eight reported setting categories: early intervention classroom, family child care, home, hospital (inpatient), outpatient service facility,[5] regular nursery school/child care, residential facility, and other.[6] The IDEA Amendments of 1997 placed greater emphasis on encouraging States to provide services in natural environments; for infants and toddlers, this is the home. In 1997, all but 10 States and Outlying Areas reported serving children in all eight categories. Alaska, Iowa, Maine, and American Samoa used seven settings categories; Minnesota and Vermont used five; the District of Columbia and Massachusetts used four; Connecticut used three; Puerto Rico used only the outpatient service facility category, and

[5] Outpatient service facility refers to an office, clinic, or hospital where an infant or toddler receives services for a short period of time; services may be offered individually or in small groups.

[6] States report on only the primary setting, or the setting in which the child receives the most hours of early intervention services.

Figure II-3
Part C Settings



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Massachusetts used only the home category. California[7] and Kentucky[8] did not report any settings data.

The variation in the use of service setting categories makes it difficult to analyze the data and discern trends. However, since 1994, the most commonly reported settings have consistently been home, early intervention classroom, and outpatient service facility (see figure II-3). In 1997, this trend continued: 58.3 percent of infants and toddlers were reported served in the home, 20.4 percent were served in early intervention classrooms, and 13.1 percent were served in an outpatient service facility (see table AH7).

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[7] California noted that it did not have reliable data to report.

[8] Kentucky said that it could not provide the information in the format requested because its data collection system could only collect data in two categories: home or community-based and office- or center-based settings.

The structure of the Part C program varies by State. The service delivery models operating in the State affect the emphasis in services, personnel, and settings. For example, Connecticut noted that its decrease in the number of infants and toddlers served in outpatient service facilities was a result of its attempt to provide services in more natural environments. Delaware, while reporting increases in other settings, reported a decrease in outpatient service facilities, which was also related to an attempt to serve children in more natural environments. Colorado noted that its increases in the home and early intervention classroom settings and decrease in other settings were largely due to more accurate reporting and categorization methods. Colorado also pointed out that it has made a concerted effort to provide more services in the home. In 1997, Colorado almost doubled the percentage of children who received the majority of early intervention services in the home (50.3 percent, vs. 28.7 percent in 1996). Other reasons given by States for year-to-year changes in the use of different service environments include a focus on serving children in natural environments; increased use of managed care, which requires that services be provided in a clinical setting; and improved reporting and categorization methods.

Summary

In 1998, for the first time since the full implementation of Part C of IDEA in 1994, the States and Outlying Areas reported a slight decline in the number of infants and toddlers served. This decline was largely the result of changes in data collection procedures in a few States. In addition, 1998 saw the first race/ethnicity data reported on birth through 2-year-olds. Most State-reported data showed no significant minority overrepresentation among the infants and toddlers served under Part C, with the exception of some States that serve the at-risk population. States continued to emphasize the home setting as a natural environment in providing services to infants and toddlers with disabilities and their families.

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Preschoolers Served Under IDEA[1,2]

The 1986 Amendments to the Education for All Handicapped Children Act (EHA)[3] changed the Preschool Grants Program for Children with Disabilities from an incentive program to a mandated program. In order to be eligible for funding under this program, funds attributable to this age under the Grants to States Program, or IDEA discretionary grants targeted to 3- through 5-year-olds, States were required to serve all eligible 3- through 5-year-olds by fiscal year 1991. States are required to have in effect policies and procedures that assure the provision of a free appropriate public education (FAPE) for all 3- through 5-year-olds with disabilities, and, at the State's discretion, to 2-year-old children with disabilities who will turn 3 during the school year.

The Individuals with Disabilities Education Act (IDEA) Amendments of 1997 revised the formula for allocating funds under the Preschool Grants for Children with Disabilities Program. Under the revised formula, each State is first allocated an amount equal to the amount it received in fiscal year 1997. For any year in which the appropriation is greater than the prior year level, 85 percent of the funds above the 1997 level are distributed based on the State's relative percentage of the total number of children ages 3 through 5 in the general population. The other 15 percent is distributed based on the relative percentage of children ages 3 through 5 in each State who are living in poverty. In addition, the IDEA Amendments of 1997 provided for situations in which the program appropriation decreases, as well as several minimums and maximums regarding the amount a State can receive during any year. These formula changes went into effect in Federal fiscal year 1998.

IDEA mandates that States report data that could be a measure of the States' progress in providing special education and related services to preschoolers with disabilities. The data analyzed in this module summarize information about the number of children ages 3 through 5 who received special education services, the racial/ethnic makeup of preschoolers in special education, and the environments in which these children received services.

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[1] This annual report includes child count data for 1998-99 and non-child count data for 1997-98.

[2] Although preschoolers are generally ages 3 through 5, some States also serve 2-year-olds who will turn 3 during the school year under Part B.

[3] In 1990, the Act was renamed the Individuals with Disabilities Education Act (IDEA).

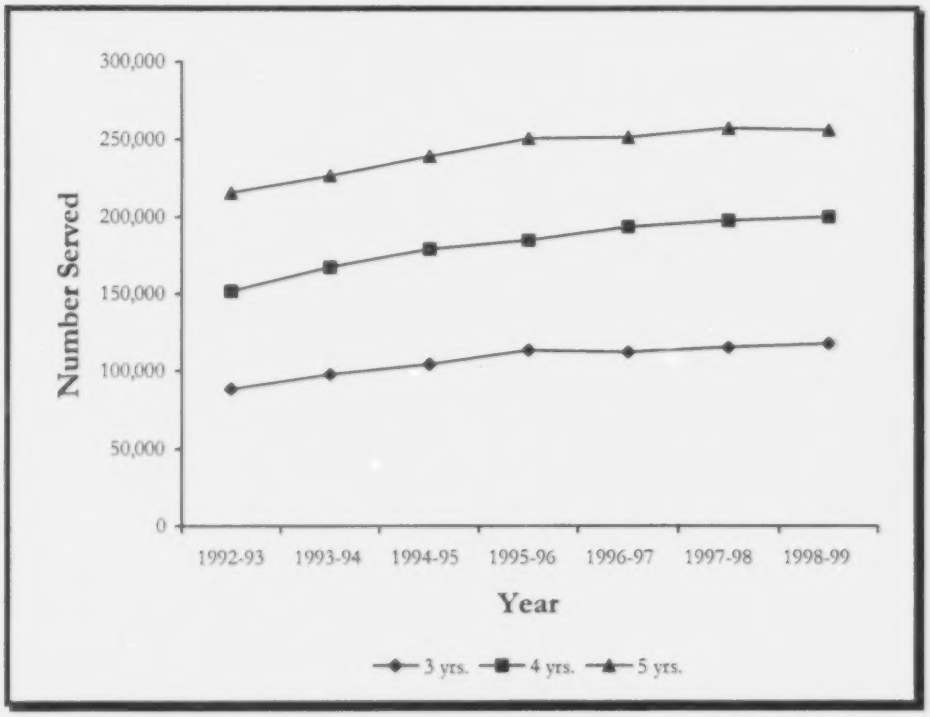
The Number of Preschool Children Served Under Part B of IDEA

During the 1998-99 school year, 573,637 preschool-aged children with disabilities were served under Part B (see table AA1). This represented approximately 4.8 percent of all preschool-aged children who lived in the United States and its Outlying Areas. However, the percentage of preschoolers served varied considerably by State. Kentucky reported the highest percentage, with 9.4 percent of its preschoolers receiving special education services. Arkansas, Maine, Wyoming, and West Virginia each reported that more than 8.0 percent of their resident preschoolers received special education and related services. California, Hawaii, Texas, and the District of Columbia reported that fewer than 4 percent of their preschool-aged children received special education services. The United States territories reported the lowest special education enrollment rates, with Palau reporting less than 1.0 percent, American Samoa 1.0 percent, and Guam 1.3 percent (see table AA12).

Special education service provision to preschoolers increased with age. Of the preschoolers who received services in 1998-99, 20.5 percent (117,698) were 3 years old, 34.9 percent (199,924) were 4 years old, and 44.6 percent (256,015) were 5 years old (see table AA9). A goal of the *U.S. Department of Education FY 2000 Annual Plan* was to identify and provide services to children with disabilities at an earlier age (U.S. Department of Education, 1999). Between 1992-93 and 1998-99, the percentage of 3-year-olds receiving services grew 33.2 percent, and the percentage of 4-year-olds receiving services increased 31.8 percent (see figure II-4). The percentage of 5-year-olds receiving services increased at a slower rate of 18.8 percent. The 1998-99 State-reported data suggest that greater numbers of younger children were being identified and provided services.

Between 1989-90 and 1998-99, the total number of preschoolers served under IDEA increased 48.8 percent (see table AA18). The past 10 years began with a slow growth of 2.4 percent between 1989-90 and 1990-91. However, the next 4 years saw the most significant growth in providing services to preschoolers with disabilities during the 1990s. Between 1991-92 and 1994-95, the number of preschool children receiving services increased by an average of 7.3 percent in each year. Growth slowed to 5.0 percent between 1994-95 and 1995-96. Over the last 3 years of the decade, the number of preschool children served under IDEA continued to grow slowly, averaging 1.5 percent per year. In fact, between 1997-98 and 1998-99, the number of preschool children receiving services increased by just 0.6 percent. This trend parallels the slower growth in the general 3- through 5-year-old population during the same period.

Figure II-4
Number of Preschool Children with Disabilities Served by Age and Year, 1992-93 Through 1998-99



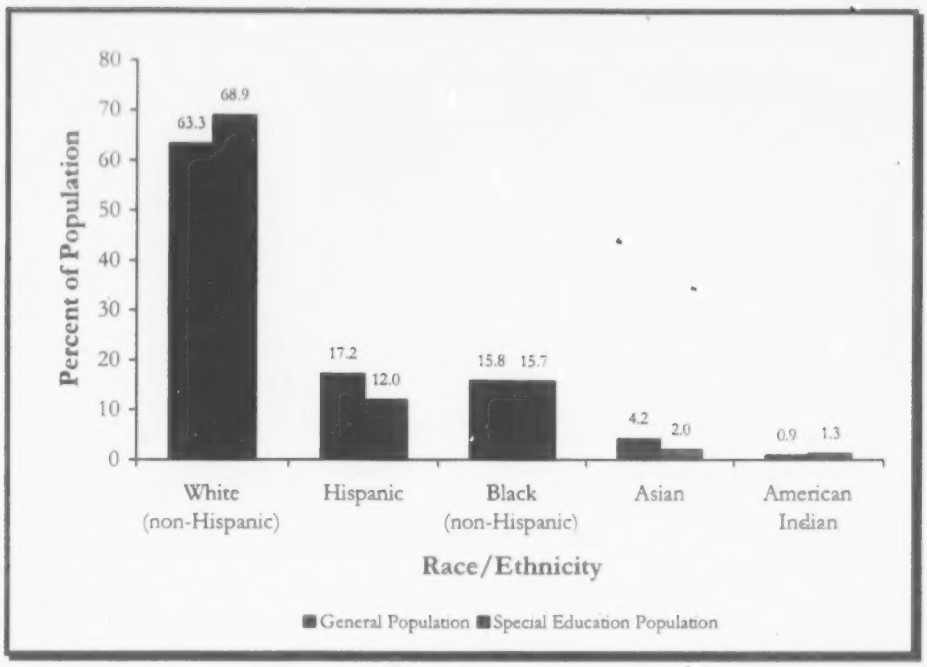
Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Race/Ethnicity of Preschoolers Served Under IDEA

In the IDEA Amendments of 1997, Congress mandated that States submit data regarding the race/ethnicity of children receiving special education and related services. This section of the module compares the racial distribution of preschoolers in special education with that of the general preschool population (see figure II-5). Since this was the first year that race/ethnicity were collected, the data should be interpreted cautiously.

U.S. Census population estimates for 1998 indicate that white children represented 63.3 percent of the general 3- through 5-year-old population, while 1998-99 State-reported data indicate that 68.9 percent of the preschoolers receiving special

Figure II-5
Race/Ethnicity of Preschoolers Receiving Special Education and of the General Preschool Population, 1998-99



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

education and related services were white (non-Hispanic). Hispanic children comprised 17.2 percent of the general preschool population but just 12.0 percent of the preschoolers receiving special education. Representation of black (non-Hispanic) children receiving Part B services appeared to be nearly comparable to the general population: 15.7 percent vs. 15.8 percent, respectively. Asian children represented 4.2 percent of the 3- through 5-year-old population, and 2.0 percent of the preschool Part B population. And 1.3 percent of preschoolers in special education were American Indian, compared with 0.9 percent of the general preschool population (see tables AA7 and AF7).

The data reported by the States for 1998-99 indicated that the racial/ethnic distribution of the general preschool population versus the special education

preschool population was, on average, generally comparable.[4] Hispanic and Asian preschool children were slightly underrepresented in the special education preschool population. Conversely, the data indicated that white, non-Hispanic children were somewhat overrepresented among preschoolers receiving special education and related services.

Educational Environments for Preschoolers with Disabilities

During 1997-98, preschool settings were defined using the same terminology as settings for school-aged children (see table II-1). However, the terms were changed in 1998-99 to reflect settings more appropriate to preschoolers.[5]

In 1997-98, Hawaii, the District of Columbia, the Northern Marianas, and the Virgin Islands did not report on educational environments for preschool-aged children with disabilities. Among the States that did report settings data, 92.2 percent of preschool-aged children with disabilities received special education and related services in a regular public school setting. Of these children, the majority (52.5 percent, or 276,839) were served in classrooms with nondisabled children for at least 80 percent of the day. Another 31.2 percent (164,512) received services in separate classes from their nondisabled peers for more than 60 percent of the school day. The remaining 8.5 percent of preschool children who received services in a regular public school were served in a resource room environment (see table AB3).

Among the preschoolers who did not receive services in a regular public school setting, a public separate facility was the most common setting for the provision of special education and related services. These students represented 3.8 percent (20,257) of the preschool children receiving IDEA services during 1997-98. Small percentages of preschoolers received special education and related services in a private separate facility (1.4 percent), public or private residential facility (0.2 percent), or a home/hospital environment (2.3 percent). For each of these settings, several States reported no children served in non-public school environments. No children were reported as receiving services in a public separate facility in 4 States, a private separate facility in 10 States, a public residential facility in 14 States, a private residential facility in 29 States, and a home/hospital environment in 8 States (see table AB3).

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[4] Comparisons were based on July 1998 U.S. Bureau of the Census estimates and were included in DANS.

[5] Data using the new settings categories will be reported for the first time in the *23rd Annual Report to Congress*.

Table II-1
Educational Settings for Children Ages 3 Through 5 with Disabilities

Regular Class: includes children who receive services in programs designed primarily for nondisabled children, provided the children with disabilities are in a separate room for less than 21 percent of the time receiving services. This may include, but is not limited to, Head Start centers, public or private preschool and child care facilities, preschool classes offered to an age-eligible population by the public school system, kindergarten classes, and classes using co-teaching models (special education and general education staff coordinating activities in a general education setting).

Resource Room: includes children who receive services in programs designed primarily for nondisabled children, provided the children with disabilities are in a separate program for 21 to 60 percent of the time receiving services. This includes, but is not limited to, Head Start centers, public and private preschools or child care facilities, preschool classes offered to an age-eligible population by the public school system, and kindergarten classes.

Separate Class: includes children who receive services in programs designed primarily for nondisabled children, provided the children with disabilities are in a separate program more than 60 percent of the time receiving services. This includes, but is not limited to, Head Start programs, public or private preschools or child care facilities, preschool classes offered to an age-eligible population in the public school system, and kindergarten classes.

Separate School (public and private): includes children who receive services in a separate program for 61 to 100 percent of the time receiving services. It does not include children who received education programs in public or private separate day or residential facilities.

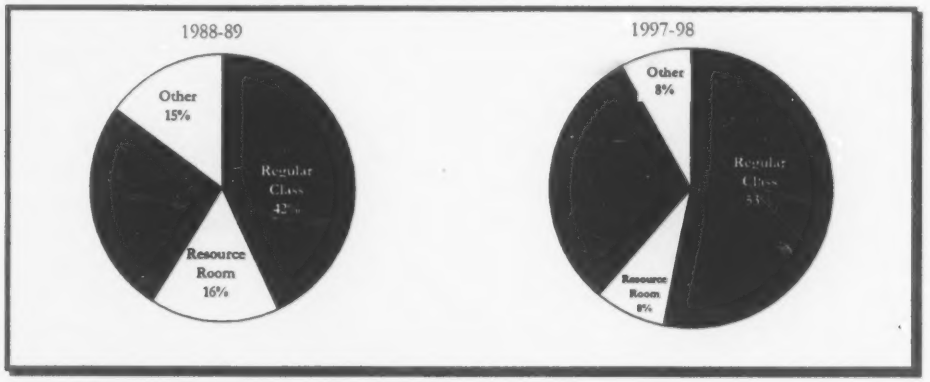
Residential Facility (public and private): includes children who are served in publicly or privately operated programs in which children receive care 24 hours a day. This could include placement in public nursing care facilities or public or private residential schools.

Homebound/hospital: includes children who are served in either a home or hospital setting, including those receiving special education and related services in the home and provided by a professional or paraprofessional who visits the home on a regular basis (e.g., a child development worker or speech services provider in the child's home). It also includes children 3 through 5 years old receiving special education and related services in a hospital setting on an inpatient or outpatient basis. However, children receiving services in a group program that is housed at a hospital should be reported in the separate school category. For children served in both a home/hospital setting and in a school/community setting, report the child in the placement that comprises the larger percentage of the time receiving services.

Source: U.S. Department of Education, Office of Special Education Programs, 1997.

Over the past 10 years, the regular classroom has been the most common service setting for preschool children with disabilities (see figure II-6). The U.S. Department of Education (1999) indicated in its FY 2000 Annual Plan that increasing inclusion of children with disabilities in regular classroom settings was an important objective in the improvement of special education. The use of the regular classroom has gradually increased from 42.2 percent in 1988-89 to 52.5 percent in 1997-98 (see table AB7). Thus, the State-reported data indicated progress toward the Department's goal of greater inclusion for preschool-aged children with disabilities.

Figure II-6
Percentage of Preschool Children Served in Different Educational Environments in 1988-89 and 1997-98



Note: Percentage may not sum to 100 due to rounding.

Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Although residential programs remained the least common service environment for preschoolers, both public and private residential programs experienced growth from the 1996-97 school year to the 1997-98 school year. The number of preschoolers served in public residential facilities rose from 700 in 1996-97 to 833 in 1997-98, an increase of 19.0 percent. After 3 years of decline, the number of preschoolers in private residential facilities rose 92.5 percent, from 173 in 1996-97 to 333 in 1997-98. In addition, the use of home/hospital programs decreased 3.3 percent between 1995-96 and 1997-98 (see table AB7). The reasons for these changes in service settings were unclear.

Summary

In the 1990s, the number of preschool children receiving special education and related services grew each year. State-reported data indicated that over the past 7 years, the number of 3- and 4-year-old children being identified and provided services grew at a much faster rate than did the number of 5-year-old children, indicating that children with disabilities were being identified and provided services at an earlier age.

Race/ethnicity data, reported for the first time in 1998-99, suggest that minority enrollment in special education was similar to the resident population of 3- through

5-year-olds. Asian and Hispanic children were slightly underrepresented among preschoolers in special education, while white (non-Hispanic) children were somewhat overrepresented.

The data reported regarding educational environments for preschool children with disabilities indicated that the majority of 3- through 5-year-olds served under IDEA received services in regular education classrooms with their nondisabled peers for 80 percent of the school day. The number of preschoolers served in regular classrooms continued to grow during the decade.

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III. SCHOOL PROGRAMS AND SERVICES

Educational Environments for Students with Disabilities

Applying Positive Behavioral Support in Schools

Office of Special Education Programs Technology and Media Services Program: A Focus on Implementation and Utilization

Additional OSEP Efforts

OSEP is undertaking a variety of tasks to study how technology is being used, or might be used, for students with disabilities. Following are examples of selected initiatives.

- **Children From Birth to 3.** Technology can play a significant role in early intervention programs and services for children from birth to age 3. IDEA has promoted the use of assistive technology services to young children through the Infants and Toddlers Program (Part C). Technology enables children to engage in the same activities as their peers who do not have disabilities. As a result, technology acts as an equalizer and further enhances opportunities for children with disabilities to be educated in less restrictive settings. A major initiative being undertaken in this area is the Birth to 3 Project. In addition to looking at effective technology for this age group, researchers also will look at the feasibility of using such technologies.

- **Futures Studies.** OSEP conducted the first "futures" study in 1984 to investigate how technologies from other sectors (e.g., medical, business, military) might be adapted to benefit students with disabilities. This initiative has been revisited every 3 to 5 years in order to identify trends and plan new directions. In the current initiative, the emphasis is on the near future. Papers are being commissioned that focus on how technology may affect students with disabilities in typical settings. These papers will be given to global futurists who will be asked to draw implications for research and practice.

- **Synthesis on the Selection and Use of Assistive Technology.** To ensure that research is disseminated fully to the field, an initiative is being undertaken to synthesize information from projects that have developed and/or studied approaches to selecting and using assistive technology, training parents, and providing local programs to support the appropriate uses of assistive technology. Information from the synthesis will form the basis for a video-based package that will be disseminated to both professional and nonprofessional audiences.

Summary

The IDEA provision to consider assistive technology reflects a growing body of knowledge demonstrating the power and potential of technology to enhance the lives of children with disabilities by providing them with access to the classroom and to

learning. However, to guarantee that technology will be used consistently and effectively for its intended purposes often requires much more than simply recommending a particular tool, putting the tool into the student's or educator's hands, or providing an afterschool staff development workshop for teachers. In many cases, particularly with more high-tech applications, technology implementation takes considerable effort and knowledge. The consideration of technology assumes an understanding of how those technologies will interact with myriad contextual factors, including stakeholders, the environment, policies, curriculum, families, and the students themselves.

The TMS program has produced a strand of inquiry that has evolved from a focus on usefulness--the potential of technology to alleviate a student need--to a focus on usefulness and utilization. TMS research has followed a pattern that is illuminating many of the contextual factors that both impede and facilitate its use. The success of technology in helping students progress ultimately will be contingent on how well these contextual factors are addressed. With OSEP's support, appropriate technology and media have been and continue to be researched, developed, demonstrated, and made available in timely and accessible formats to parents, teachers, and other personnel who provide services to children with disabilities.

IV. RESULTS

Characteristics of Children and Families Entering Early Intervention

High School Graduation

State Improvement and Monitoring

Characteristics of Children and Families Entering Early Intervention

In 1986, P.L. 99-457 created the Early Intervention Program for Infants and Toddlers with Disabilities, now contained in Part C of the Individuals with Disabilities Education Act (IDEA), as amended in 1997. The ensuing years have seen steady growth in the number of infants and toddlers served under Part C, increasing from an estimated 128,000 in 1988 (U.S. Department of Education, 1990) to almost 200,000 in 1997 (U.S. Department of Education, 1998). Yet very little is known about the characteristics of these children or their families, about the services they receive, or about the outcomes they achieve.

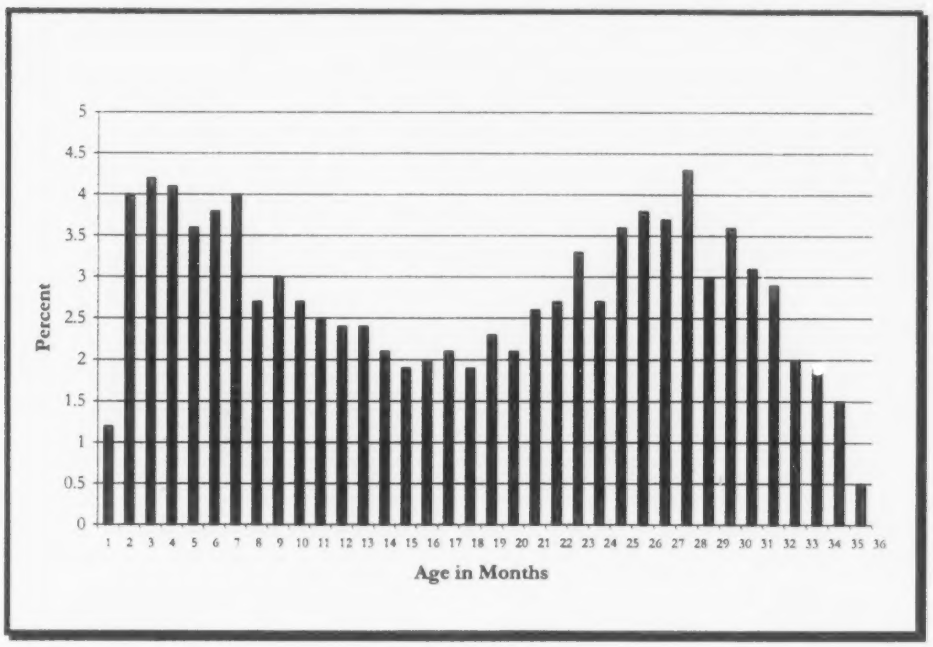
To meet the need for more and better information about Part C and its participants nationally, the Office of Special Education Programs (OSEP) commissioned the National Early Intervention Longitudinal Study (NEILS). NEILS began in 1996 with a design phase; data collection began the following year. NEILS findings are based on a nationally representative sample of children and families who were recruited into the study as they entered early intervention. Study recruitment extended from September 1997 through November 1998. Information will be collected repeatedly about participating children and families through their early school years.

The following pages present preliminary descriptive information from NEILS about the children and families entering early intervention services. These data address the reasons for which they are receiving early intervention services, the ages at which children are entering early intervention, and some demographic characteristics of this population. The data presented here are based on a one-page form that early intervention program staff completed on all children and families who entered early intervention for the first time during the study recruitment period (n=5,668). Additional information about the study methodology is available in Hebbeler, Wagner, and Spiker (2000).

Age at Entry and Reasons for Receipt of Early Intervention

The philosophical and empirical basis for early intervention is that providing appropriate services early is of potentially greater impact than beginning services later. Accordingly, an important policy goal is to identify and serve children with developmental problems in programs as early as possible. The average age at which

Figure IV-1
Age at Time of Individualized Family Service Plan (IFSP)



Source: National Early Intervention Longitudinal Study.

children were referred for early intervention was 15.5 months (S.E.=.66[1]). Average age at the completion of the individualized family service plan (IFSP) was 17.1 months (S.E. =.72).

Average age tells only part of the story. Children entered early intervention at every month between birth and 36 months, but there are particular months at which children were more likely to enter. Figure IV-1 shows the distribution of the ages in months of children at the time of the IFSP. Each bar shows the percentage of all entering children under 36 months who were a given age at entry. As the graph illustrates, more children entered early intervention in the first and third year of life than in the second. More than 38 percent of children entering early intervention for the first time did so between birth and 12 months; in fact, more than one in five entered early intervention in their first 6 months. Another 28 percent entered in their

[1] The S.E. or standard error indicates the precision of the estimate. To determine the precision of a particular percentage or mean, the reader can construct a confidence interval for the estimate by multiplying the standard error by 1.96. The result is the range around the estimate within which the true measure would be found 95 out of 100 times.

second year, and more than one-third of children entered early intervention after their second birthdays.[2]

IDEA stipulates the parameters for who is to receive early intervention services. A child is to be provided early intervention services because s/he (i) is experiencing developmental delays in one or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development; or (ii) has a diagnosed physical or mental condition which has a high probability of resulting in developmental delay." The Federal law also allows States to serve children considered to be "at risk of experiencing a substantial developmental delay if early intervention services were not provided to the individual" (20 U.S.C. §1432, as amended by the Individuals with Disabilities Education Act of 1997).

Early intervention program staff were asked to describe the nature of the disability, delay, or risk condition for which the child was eligible for early intervention. Staff provided descriptors such as "motor delay" or "intraventricular hemorrhage." This information was provided for 93 percent of the children. A total of 305 different terms were provided. The average number of different descriptors for children with at least one descriptor (n=5,293) was 1.5; the range was 1 to 11. These descriptors were then coded as a developmental delay, an established condition, or a risk condition using a classification scheme developed by the research team.

As shown in table IV-1, the most frequently reported reason for receipt of early intervention was a speech/communication impairment or delay. Providers indicated that 41 percent of the children were eligible for early intervention for problems related to speech or communication. The reader is advised that these data are limited by what providers choose to write down about a child. For children with multiple delays or impairments, some providers probably opted to write down the one or two primary reasons for receipt of services. The percentages are thus conservative estimates of presenting problems and are probably more accurately thought of as minimums. The finding is that *at least* 41 percent of the children entering early intervention had speech or communication problems.

[2] Figure IV-1 shows a noticeable dip around the age of 15 months because children tend to be identified for early intervention services at two key points: at birth, when some congenital disabilities are immediately apparent and, in the second year, when children fail to meet some crucial developmental milestone.

Table IV-1
Frequency of Reasons for Receipt of Early Intervention and Age at IFSP (n=5,293)

	Reason for EI		Age at IFSP		
	Percentage	Standard Error	Average Age (Months)	Standard Error	N
Delayed development (global)	12.24	1.15	17.64	.97	701
Physical growth abnormality a/	1.58	.36	15.34	1.91	87
Sensory systems impairment	3.27	.39	15.73	.89	167
Vision impairment a/	1.07	.13	11.92	1.18	61
Hearing impairment a/	1.92	.41	15.89	.48	91
Motor impairment or delay	17.49	1.81	15.16	.33	934
Physiological or neurological system impairment	2.22	.45	10.84	.94	123
Intellectual/cognitive impairment or delay	7.18	1.36	22.72	1.00	380
Social/behavioral impairment or delay	3.74	.64	22.15	.70	209
Speech/communication impairment or delay	41.07	3.9	24.87	.29	2,153
Delay in self-help skills	2.55	.74	20.19	.99	151
Congenital disorders	8.90	.94	7.86	.69	502
Down syndrome a/	4.31	.48	5.80	.80	252
Prenatal/perinatal abnormalities	18.92	2.62	8.21	.59	1,020
Low birth weight a/	10.99	1.64	7.17	.79	588
Prenatal exposure to drugs/ alcohol a/	2.08	.60	11.46	.82	97
Illness or chronic disease	1.85	.31	13.56	1.59	91
Musculoskeletal disorders	1.96	.23	8.9	.96	98
Central nervous system disorders	6.53	.56	12.2	.51	339
Cerebral palsy a/	2.19	.28	17.03	1.19	118
Receiving medical treatment, disorder not identified	1.39	.35	9.13	1.5	73
Social environment risk factors	3.90	1.11	15.20	1.4	172

Note: Children could have more than one reason for the receipt of early intervention.

a/ Indented categories are also included in the superordinate category ab vc them.

Source: National Early Intervention Longitudinal Study.

Other frequently reported reasons for the receipt of early intervention included prenatal/perinatal problems (19 percent), with the most frequent of these being low birth weight (11 percent of children in early intervention), motor delays (17 percent), and an overall delay in development (12 percent).

Children entering early intervention for different reasons entered at different ages. Table IV-1 also presents the average age at IFSP for different types of disability, delay, or risk conditions. There are highly significant but not surprising differences in the ages at which children with different conditions are entering early intervention. Children with congenital disorders were the youngest group at entry to early intervention with an average age at IFSP of 7.9 months. Many of these conditions are identifiable at birth, and these children therefore should be entering early intervention very young. Children with prenatal and perinatal abnormalities also entered early intervention young relative to other conditions, with the average age at IFSP being 8.2 months. Children with physical growth abnormalities, sensory impairments, or motor delays entered at around 15 months on average. Children with motor, intellectual, social or speech/communication delays or impairments began early intervention around age 2.

Another way to examine the relationship between age at entry and disability is to look at the percentage of children who enter in the first, second, or third year of life with particular conditions. For children who began early intervention at less than 12 months of age, the most frequent reason for receiving services was perinatal/prenatal abnormalities (at least 40 percent of those who entered at less than 12 months), with low birth weight being the largest type of perinatal/prenatal abnormality (28 percent of children younger than 12 months). The second most common reason for receipt of services for this age group was for motor delays or impairments (20 percent).

The pattern is quite different for older infants. For children who began services between the ages of 12 and 24 months, the most frequent reason for receipt of early intervention was a speech/communication delay or impairment (49 percent), followed by motor delay (22 percent) and global developmental delay (15 percent). For the oldest children entering early intervention, those over 24 months, three-fourths (75 percent) of the children entered early intervention with speech/communication delays. The next most frequent conditions were intellectual/cognitive delays (12 percent), global developmental delay (12 percent), and motor delays (11 percent).

Reasons for eligibility for early intervention can also be examined with regard to the three eligibility categories in IDEA. Grouping the various disability descriptors into

Table IV-2
Frequency and Average Age at IFSP for Developmental Delay, Diagnosed Condition, and At Risk (n= 5,293)

	Frequency		Age at IFSP		
	Percentage	Standard Error	Average Age (Months)	Standard Error	N
A developmental delay	64.10	4.62	21.25	.43	3,425
A diagnosed condition	20.37	2.15	10.71	.44	1,078
Being at risk of developmental delay	15.53	2.72	8.45	.73	790

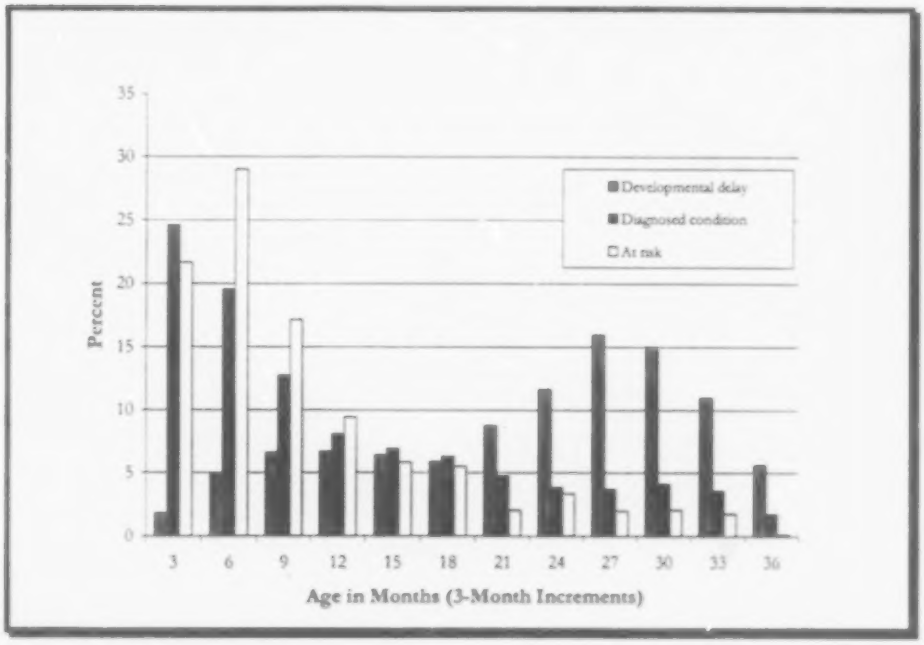
Source: National Early Intervention Longitudinal Study.

the three eligibility classifications in the law shows that most children were eligible for early intervention because of a developmental delay (64 percent), a lesser proportion had a diagnosed condition (20 percent), and far fewer were being served because they were at risk (16 percent)[3] (see table IV-2). Children with more than one of these were coded into one category, giving priority to the order in which the terms were just listed (e.g., developmental delay co-occurring with a diagnosed condition was coded as developmental delay for the 4 percent of children with both.)

The average age of children at IFSP differed markedly across the three reasons (see table IV-2). Children who were eligible for early intervention primarily because of a developmental delay were significantly older on average at entry (21.3 months) than children entering because of a diagnosed condition (10.7 months) or being at risk of delay (8.5 months) (for all comparisons, $p<.05$). This is not surprising because developmental delays can only be diagnosed when children are old enough to be expected to have developed particular skills and have not yet done so. Some common diagnosed conditions, in contrast, are evident at birth (e.g., Down syndrome, spina bifida) as are some factors that put children at risk for delay (e.g., drug or alcohol exposure, low birth weight).

[3] Seven of the 20 States in the study sample were serving at-risk children under Part C at the time these data were collected. Not all of the children classified by the NEILS' categorization scheme as having risk conditions were residents of States that served at-risk children. This apparent anomaly occurs because the dividing line between established conditions and risk conditions is not well defined in practice, with the same conditions being seen by some States as established conditions and other States as risk conditions. Low birth weight is one example of such a condition.

Figure IV-2
Age at IFSP by Reasons for Eligibility



Source: National Early Intervention Longitudinal Study.

Figure IV-2 illustrates the different patterns of age at IFSP for the three groups. Each bar shows the percentage of children eligible for that reason who entered early intervention in the 3-month age grouping (e.g., birth to 3 months). Children with diagnosed conditions or risk conditions entered in greater numbers in the first year of life, while children with developmental delays were more likely to be identified in the later part of the first 3 years of life. Of children who were eligible for early intervention primarily because of a diagnosed condition, 44 percent entered early intervention in their first 6 months of life, as did 51 percent of those who were eligible primarily because they were at risk of delay. By contrast, only 7 percent of those who were eligible for early intervention because of developmental delay were younger than 6 months old at entry. Forty-seven percent of children with developmental delays entered early intervention between 24 and 31 months of age, compared to 17 percent of children with diagnosed conditions and 10 percent of children who were at risk.

Table IV-3
Demographic Characteristics of Children Entering Early Intervention

	Percentage	Standard Error	N
Gender			5,663
Male	60.91	1.09	
Race/ethnicity			5,376
African American	21.49	1.23	
American Indian or Alaska Native	.48	.20	
Asian or Pacific Islander	4.84	1.86	
Caucasian	55.60	1.98	
Hispanic	15.19	2.30	
Mixed race or "other"	2.41	.47	
Socioeconomic status			
Received public assistance	42.20	1.76	5,180
No working telephone at home	5.48	.52	5,631
In foster care	7.03	.58	5,636

Source: National Early Intervention Longitudinal Study.

Demographic Information

As part of sample recruitment for NEILS, minimal demographic information was collected on all children and families who enrolled in early intervention during the timeframe. Much more demographic information will be available on the children and families who enrolled in the study, but even these minimal data provide interesting information about who is receiving early intervention services.

Gender

Six of 10 children entering early intervention were boys (see table IV-3), a higher rate than their prevalence in the general population of children less than 3 years old (51 percent, U.S. Bureau of the Census, 1998). The disproportion of boys was strongest among those with developmental delays; 65 percent (S.E.=1.79) of these children were male compared to 52 percent (S.E.=1.95) for children with diagnosed conditions and 54 percent (S.E.=3.51) for those at risk of delay ($p<.001$). The overrepresentation of boys in special needs populations has been noted among older children as well (U.S. Department of Education, 1998). Among those with

developmental delays, males were older on average than females at entry to early intervention (22.1 months, S.E.= .38 vs. 19.6 months, S.E.=.51, $p<.001$).

Race and Ethnicity

Children of color were represented in the early intervention population more heavily than in the general population. Whereas 37 percent of the general population of children ages birth to 3 in 1997 were minority, 44 percent (S.E.=1.98) of children entering early intervention during the study period were minority. Most of the disproportion of children of color results from a higher percentage of African American children (21 percent, S.E.=1.23) entering early intervention relative to their numbers in the general population of young children (14 percent). The percentage of children of Hispanic[4] origin entering early intervention approximated the percentage in the current population: 15 percent (S.E.=2.30) of those entering early intervention were Hispanic, compared with 18 percent in the general population. Asian/Pacific Islander children were 4.8 percent (S.E.=1.86) of those entering early intervention, compared with 4.3 percent of the general population of children birth to age 3. American Indian/Alaska Native children made up less than 1 percent of both the population of children in early intervention and the general population (.5 percent vs. .9 percent, S.E.= .2).

Receipt of Public Assistance

Childhood poverty is associated with a variety of detrimental effects on children's development, including physical health, cognitive ability, school achievement, emotional and behavioral outcomes, and later teenage out-of-wedlock childbearing. Poverty that occurs earlier in children's lives and extends over more years has been found to have particularly negative effects (Brooks-Gunn & Duncan, 1997). Poverty occurring in families with young children also can place considerable stress on the families raising them; in fact, poverty has been the one factor most consistently related to child abuse and neglect (Sedlak & Broadhurst, 1996).

Although the enrollment information does not contain a direct measure of poverty, early intervention professionals did report whether the families whose children were entering early intervention received any kind of public assistance (e.g., Temporary Assistance to Needy Families (TANF), food stamps). A large proportion of children entering early intervention were in families who received some kind of public

[4] Children were classified as Hispanic apart from the racial classification. In reducing these two variables to a single variable, Hispanic children were classified as Hispanic regardless of race whereas other children are classified by the racial category.

assistance (42 percent, S.E.=1.76).[5] This is significantly higher than the rates at which children in the general population received Aid to Families with Dependent Children (AFDC) or general assistance (13.4 percent in 1995; U.S. Department of Health and Human Services, 1999) or food stamps (20.3 percent in 1995; U.S. Department of Health and Human Services, 1999). Children from families in early intervention receiving public assistance were more likely to be minority than children in families not receiving public assistance; 62 percent (S.E.=4.54) of the families receiving public assistance were minority families compared to 30 percent (S.E.=2.3) of those not receiving public assistance.

Children from families receiving public assistance and not receiving public assistance differed in their reasons for eligibility for early intervention. Fewer children in families receiving public assistance were eligible for early intervention because of a developmental delay (61 percent, S.E.=4.73) compared to 67 percent (S.E.=4.48) of families not receiving public assistance ($p<.001$). More children in families receiving public assistance were eligible because of a risk condition (19 percent compared to 12 percent for children in families not receiving public assistance, S.E.s=3.66 and 1.84, respectively).

Children with developmental delays in families receiving public assistance were younger, average age of 19.3 months (S.E.=.58), at entry to early intervention than children with developmental delays in other families, who averaged 22.6 months (S.E.=.37, $p<.05$). This could be because their delays were more serious, because they may be seen by pediatricians and other service providers more often or who were more attuned to possible delays, or a combination of these.

Almost 6 percent (S.E.=.52) of families had no working telephone at home. The lack of a telephone probably means these families have a more difficult time communicating with early intervention professionals about their child and their services which could translate into less service (e.g., missed home visits) or less effective service for these families.

Foster Care

The frequency of foster care placements for children in this country has increased in recent years, from approximately 262,000 children in 1982 to 483,000 in 1995 (U.S.

[5] Early intervention professionals were asked to indicate whether anyone in the household "received any kind of public assistance. Public assistance can include food stamps, public housing, welfare benefits (AFDC, TANF), etc." The kind of public assistance received was not recorded. Additional information about the type of assistance received by families in early intervention will be forthcoming from other NEILS data.

Department of Health and Human Services, 1999). More than half of children in foster care are placed there to protect them from adults in their own homes (Tatara, 1990). Seven percent of children entering early intervention were in foster care, a rate about 10 times the rate at which children in the general population are in foster care (7.3 children per thousand, U.S. Department of Health and Human Services, 1999).[6] Although the magnitude of this finding is somewhat surprising, its occurrence is not. The same unfortunate life circumstances that have resulted in children being in foster care (e.g., maternal drug abuse, poverty, neglect) may also have significantly impaired their development and certainly place children at risk for developmental problems. Foster care children entering early intervention present a particularly urgent demand for coordinated services across multiple systems, often including child welfare, public health, mental health, and early intervention.

Children in foster care were less likely to receive services for a diagnosed condition (13 percent, S.E.=2.12, compared to 21 percent, S.E.=2.23) than children not in foster care ($p<.001$) and more likely to receive services for a risk condition than children not in foster care (22 percent vs. 15 percent, S.E.s=6.55 and 2.47). Early intervention recipients in foster care were overwhelmingly African American (60 percent, S.E.=4.9). By contrast only 20 percent (S.E.=2.96) of children in early intervention and foster care were Caucasian. With 45 percent of the children under 18 in foster care being African American, there are also a disproportionate number of African American children in foster care in the general population (U.S. Department of Health and Human Services, 1999).

Children in foster care also were significantly more likely to be living with families receiving public assistance. Three-fourths (74 percent, S.E.=5.29) of families with foster children were receiving public assistance compared to 40 percent (S.E.=1.92) of families of children not in foster care ($p<.001$). It is not clear, however, if this means 75 percent of the families with foster care children were low-income families. Service providers might have indicated the family was receiving public assistance because they were receiving public funds for the foster child. Additional information on this point will be available through the family interviews.

[6] Early intervention professionals who enrolled children were asked to report if the child is cared for by someone in a foster care arrangement (e.g., placed with a family by a social services agency), whether or not the child has a legal foster parent. The difference between the foster care placement rate of children entering early intervention and that for the general population may be affected to an unknown degree by the difference in age between the two groups. The early intervention population is children younger than 3, whereas the figure for the general population includes all children younger than 18.

Summary

Who are the children and families entering early intervention? Preliminary data from NEILS indicate that most children are eligible for early intervention because of a developmental delay, and these children are likely to enter early intervention later than children with a diagnosed condition or a risk condition.

Children enter early intervention at every point throughout the first 3 years of life, but there are time points at which children are more likely to enter: in the first year and third year of life. Children with diagnosed conditions and risk conditions constitute the majority of children entering before the first birthday. Children with developmental delays are the majority of those entering after their second birthday. The primary reasons for eligibility for those who begin services as infants are prenatal or perinatal abnormalities, followed by motor delays or impairments. Older children are most likely to be eligible because of a speech/communication impairment or delay. Motor delays continue to be identified through toddlerhood.

These initial findings on the demographic characteristics of children in early intervention have shown that they are not a representative cross-section of the birth to 3 population. There are more males in early intervention. Families in early intervention are more likely to be receiving some form of public assistance.

The findings reported here are based on the first data from NEILS, and considerably more information will be available in the future. Analyses of data from the family interviews will provide more data on the characteristics of children and families receiving early intervention, such as information about the children's functioning and their families' initial experiences with early intervention. Detailed information about the nature, amount, and location of services will be forthcoming from data collected from service providers. Program directors and program providers were also surveyed, and those surveys will provide profiles of the types of programs serving young children and their families as well as information about who is providing those services. Finally, NEILS will also collect data on the costs of early intervention services and will relate those costs to the benefits achieved.

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State Improvement and Monitoring

One of the primary purposes of the Individuals with Disabilities Education Act (IDEA) is to assess the impact and effectiveness of State and local efforts to provide early intervention and educational services to infants, toddlers, children, and youth with disabilities. Primarily through OSEP, the Department of Education assists States, local early intervention providers, and school districts in implementing IDEA's provisions by making grants pursuant to congressional appropriations and providing technical assistance, policy support, and monitoring oversight.

OSEP works in partnership with: (1) States, early intervention services providers, families of infants and toddlers with disabilities, institutions of higher education, advocacy groups, and others to ensure positive results for infants and toddlers and their families and (2) States, parents, school districts, school administrators and teachers, institutions of higher education, students with disabilities and their families, advocacy groups, and others to ensure positive educational results for students with disabilities. OSEP uses research, dissemination, demonstration, systems change, and other technical assistance strategies to provide State and local early intervention providers and educational agencies with tools to assist them in improving results.

OSEP has been working with States, parents, and other advocates over the past 5 years, and with even greater intensity since the enactment of the IDEA Amendments of 1997, to shape OSEP's accountability work in a way that drives and supports improved results for infants, toddlers, children, and youth with disabilities without sacrificing any effectiveness in ensuring that the individual rights of children with disabilities and their families are protected. In order to ensure compliance that supports strong results for people with disabilities, OSEP has used a multifaceted process that has included the following:

- Providing ongoing technical assistance to States regarding legal requirements and best practice strategies for ensuring compliance in a manner that ensures continuous progress in results;
- Reviewing each State's statutes and regulations and other policy and technical assistance documents, and documentation of the State's exercise of its general supervision responsibilities, including monitoring and complaint resolution;
- Conducting onsite visits and other activities to ensure *implementation* of policies and procedures that are consistent with the requirements of IDEA and that support reform and strong results;

- Ensuring correction of noncompliance in a manner that supports improved results and reform; and

- Engaging in ongoing communication with States, national and State organizations, parents and advocates, and other constituents.

On February 17, 18, and 19, 1998, OSEP hosted a working meeting with diverse representation from stakeholder groups, including State coordinators of early intervention services and directors of special education, Parent Training and Information Centers, Regional Resources Centers, the National Early Childhood Technical Assistance System (NECTAS), and parent and child advocacy groups. OSEP asked the participating stakeholders to help it define a vision for compliance with certain results-oriented requirements and to develop monitoring strategies to determine the level of implementation of the requirements. Finally, OSEP asked the participants to propose a monitoring system that would incorporate the results-oriented monitoring strategies. OSEP used the input from this very productive stakeholder meeting to design its Continuous Improvement Monitoring Process, which is built around the following critical themes:

Continuity. An effective accountability system must be continuous, rather than episodic, clearly linked to systemic change, and integrate self-assessment and continuous feedback and response.

Partnership with Stakeholders. OSEP must be a partner with parents, students, State and local educational agencies, and other Federal agencies in a collaborative process in which stakeholders are part of the entire process, including the setting of goals and benchmarks; the collection and analysis of self-assessment data; the identification of critical issues and solutions to problems; and the development, implementation, and oversight of improvement strategies to ensure compliance and improved results for children and youth with disabilities.

State Accountability. States must assume accountability for measuring and reporting progress, identifying weakness, and identifying and implementing strategies for improvement.

Self-Assessment. Each State must work with stakeholders to design and implement an ongoing self-assessment process that is focused on improving results for children and youth with disabilities and that facilitates continuous feedback and use of information to support continuous improvement. OSEP will periodically visit programs in the State to verify the self-assessment.

Data Driven. The continuous improvement monitoring process in each State will be driven by data that focus on improved results for children and youth with disabilities. Each State will collect and use data on an ongoing basis, aligned with the State's performance goals and indicators, with regular OSEP review. States and OSEP will compare data across States, school districts, and early intervention service providers to identify needs and strategies for improvement. Some of the available data which can be critical to the self-assessment and validation process include those regarding graduation and dropout rates, performance of students with disabilities on state- and district-wide assessments, rates at which children with disabilities are suspended and/or expelled from school, and identification and placement of students from minority backgrounds.

Public Process. It is important that the self-assessment and monitoring process be public and that self-assessment results, monitoring reports, and improvement plans be broadly disseminated.

Technical Assistance. Because the focus of the monitoring process is on continuous improvement, technical assistance is a critical component. Therefore, OSEP will prioritize the provision of such assistance as a component of its onsite work in each State. States will be encouraged to include a technical assistance plan as part of their correction/improvement plan and utilize the Regional Resource Centers and NECTAS to provide and broker technical assistance throughout the continuous improvement process. A key component in technical assistance will be the identification and dissemination of promising practices.

OSEP customizes its continuous improvement monitoring process to meet the needs in each State. In States where there is evidence of substantial compliance with IDEA requirements, OSEP's focus is on the identification and implementation of promising practices. In States that are not demonstrating compliance, OSEP works with the State to develop improvement strategies. States that fail to correct identified deficiencies may be subject to enforcement actions such as special conditions on grant awards, compliance agreement, or withholding of funds.

The continuous improvement monitoring cycle is ongoing and consists of the following phases:

Self-assessment. The State works with a steering committee of stakeholders who represent diverse perspectives to develop and implement a self-assessment to evaluate the State's effectiveness in achieving compliance and in improving results for children and youth with disabilities and their families.

Validation Planning. The steering committee, made up of representatives of stakeholder groups and selected by the State education agency (SEA) and lead agency, works with OSEP staff to plan strategies for validating the self-assessment results, including, if appropriate, onsite collection of data. The validation planning stage includes meetings to obtain focused public input, review the self-assessment, and develop a monitoring plan, which can include offsite and/or onsite strategies.

Validation Data Collection. During this phase, OSEP collects validation data, presents those data to the steering committee in a structured exit conference, and works with the steering committee to plan the reporting and public awareness processes. OSEP's data collection may include data collection at both the State and local levels.

Improvement Planning. Based upon the self-assessment and validation results, the steering committee develops an improvement plan that addresses both compliance and improvement of results for children and youth with disabilities and includes timelines, benchmarks, and verification of improvement. OSEP encourages States to include their Regional Resource Center and/or NECTAS in the development of the improvement plan, in order to facilitate the effective inclusion of technical assistance in both planning and implementation of the improvement plan.

Implementation of Improvement Strategies. The State implements and evaluates the effectiveness of the improvement plan.

Verification and Consequences. Based upon documentation that OSEP receives from the State and steering committee, OSEP verifies effectiveness of the actions taken in implementing the improvement plan. Where the State has been effective in achieving verifiable improvement, positive consequences may include public recognition. If a State does not implement the improvement plan, or implementation is not effective, OSEP may need to impose sanctions, which could include OSEP's prescription of improvement actions, a compliance agreement, or other enforcement actions.

Review and Revision of Self-assessment. Based on the results of the previous improvement planning cycle, the State reviews, and as appropriate revises, the self-assessment.

OSEP has focused its continuous improvement monitoring process on those areas that are most closely associated with positive results for children with disabilities. To help OSEP and States focus on those areas, OSEP has clustered:

1. Part C (services for children ages birth through 2) requirements into five major areas:

   - General Supervision,
   - Child Find and Public Awareness,
   - Early Intervention Services in Natural Environments,
   - Family-Centered Systems of Services, and
   - Early Childhood Transition.

2. Part B (services for children ages 3 through 21) requirements into four major areas:

   - Parent Involvement,
   - Free Appropriate Public Education in the Least Restrictive Environment,
   - Secondary Transition, and
   - General Supervision.

In order to assist States in the self-assessment of their systems for early intervention and special education services, and to guide OSEP's review of those systems, OSEP developed "cluster charts," that included results-focused State and local indicators for each of the nine clusters listed above. The self-assessment and monitoring process incorporates use of the cluster areas through the following steps:

- Identifying indicators for measuring progress in the implementation of IDEA;
- Identifying potential data sources and gathering data pertinent to the indicators;
- Analyzing the data to determine the positive and negative differences between the indicators as stated and their status; and
- Identifying promising practices and developing improvement and maintenance strategies.

Table IV-5
Schedule of 1998-1999 Continuous Improvement Monitoring Reviews

North Dakota August/September 1998	Utah October/December 1998	New York February/April 1999
Nebraska August/October 1998	Arizona October 1998/January 1999	Montana March/April 1999
Washington August/October 1998	Wisconsin November 1998/February 1999	South Dakota March/May 1999
New Mexico October/December 1998	Massachusetts November 1998/February 1999	Bureau of Indian Affairs (Data collected during North Dakota, New Mexico, and South Dakota visits)

Source: U.S. Department of Education, Office of Special Education Programs, Division of Monitoring and State Improvement Planning.

OSEP conducted 12 continuous improvement monitoring reviews during the 1998-99 school year. During the 1999-2000 school year, OSEP conducted six reviews, as well as the validation planning visit component for two additional States. OSEP will conduct the validation data collection visits for those two States at the beginning of the 2000-01 school year. In addition, in 1999-2000 OSEP made a visit to Illinois for Part B focus and Part C follow up, and two CAP visits to California. Table IV-5 shows the schedule of the 1998-99 school year reviews; table IV-6 lists the 1999-2000 reviews.[1]

OSEP's monitoring reports for the 1998-99 and 1999-2000 school year reviews are, like the self-assessment, validation planning, and data collection processes, focused around the five Part C and four Part B clusters described above. The following is a summary of the strengths and areas of noncompliance that OSEP identified in the monitoring reports that it has issued based upon visits in the 1998-99 school year.

Part C: General Supervision and Administration

The State lead agency is responsible for developing and maintaining a statewide, comprehensive, coordinated, multidisciplinary, interagency early intervention system. Administration, supervision, and monitoring of the early intervention system are essential to ensure that each eligible child and family receives the services needed to enhance the development of infants and toddlers with disabilities and to minimize

[1] Monitoring reports are available online at http://www.ed.gov/offices/OSERS/OSEP or by writing to the OSEP director at the Department of Education.

Table IV-6
Schedule of 1999-2000 Continuous Improvement Monitoring Reviews

Illinois September 1999 (Part B focus/C follow-up)	Colorado November 1999/January 2000
Ohio August/October 1999	Florida December 1999/February 2000
Maryland September/October 1999	New Jersey February/September 2000
Louisiana November 1999/February 2000	Pennsylvania March/October 2000
Arkansas November 1999/January 2000	California January/April 2000 (CAP visits)

Source: U.S. Department of Education, Office of Special Education Programs, Division of Monitoring and State Improvement Planning.

their potential for developmental delay. Early intervention services are provided by a wide variety of public and private entities. Through supervision and monitoring, the State ensures that all agencies and individuals providing early intervention services meet the requirements of IDEA, whether or not they receive funds under Part C.

While each State must meet its general supervisory and administrative responsibilities, the State may determine how that will be accomplished. Mechanisms, such as interagency agreements and/or contracts with other State-level or private agencies can serve as the vehicle for the lead agency's implementation of its monitoring responsibilities. The State's role in supervision and monitoring includes: (1) identifying areas in which implementation does not comply with Federal requirements; (2) providing assistance in correcting identified problems; and (3) as needed, using enforcing mechanisms to ensure correction of identified problems.

During Part C monitoring, OSEP identified strengths in the General Supervision Cluster in the following areas: (1) Interagency Coordinating Councils with strong parent representation and active participation by agencies involved in providing services for infants, toddlers, and their families and (2) an efficient Interagency Coordinating Council resulting in creative practices in the areas of personnel preparation, effective interagency agreements, and innovative and family-centered practices leading to improved results for infants, toddlers and their families. In addition, OSEP discovered that some States have sophisticated data collection systems that provide them with information to effectively plan in all areas of the early intervention system to ensure appropriate family-centered services. One State has implemented a joint monitoring process that minimizes duplication of effort and

promotes efficiency. These interagency monitoring activities have been effective in identifying and correcting deficiencies in the Part C program.

Areas of noncompliance identified by OSEP included States that do not have an effective or complete monitoring system to ensure compliance with all Part C requirements. There is wide variation in States' monitoring activities and in the components that are covered in a State's monitoring system. Some States have not yet conducted a systematic monitoring and evaluation of their Part C program. Other States that have conducted monitoring activities have not included important components of Part C, such as monitoring for natural environments and family-centered practices; ensuring that eligible children and families are receiving all needed services, timely evaluation and assessment activities, and individualized family service plan (IFSP) development; ensuring distribution of public awareness materials by primary referral sources; and a variety of other aspects of Part C requirements. States that identify noncompliance issues frequently have ineffective improvement actions or enforcement strategies, as the same issues recur in subsequent monitoring by the State and were also identified during OSEP's monitoring activities. Furthermore, some States are neglecting to ensure that all programs and agencies providing early intervention services are in compliance with Part C, especially if the service provider is another State agency.

Part C: Child Find/Public Awareness

The needs of infants and toddlers with disabilities and their families are generally met through a variety of agencies. However, prior to the enactment of Part C of IDEA, there was little coordination or collaboration for service provision, and many families had difficulty locating and obtaining needed services. Searching for resources placed a great strain on families. With the passage of Part C in 1986, Congress sought to ensure that all children needing services would be identified, evaluated, and served, especially those children who are typically underrepresented, (e.g., minority, low-income, inner-city, American Indian, and rural populations), through an interagency, coordinated, multidisciplinary system of early intervention services.

Each State's early intervention system must include collaborative child find and public awareness activities that are coordinated with all other child find efforts in the State. Part C recognizes the need for early referral and short timelines for evaluation because development occurs at a more rapid rate during the first 3 years of life than at any other age. Research in early brain development has demonstrated what early interventionists have known for years--that children begin to learn and develop from the moment of birth. Therefore, the facilitation of early learning and the provision of timely early intervention services to infants and toddlers with disabilities are critical.

OSEP observed areas of strengths in States' public awareness campaigns. For example: (1) An effective statewide multimedia public awareness campaign is reaching urban areas; (2) State early intervention staff participate in statewide early childhood initiatives to promote awareness of Part C; (3) program materials are available in multiple languages and easy-to-read formats; (4) funds are provided to reservation tribes for development of materials to foster child find activities for Native American children. OSEP noted strengths in States' comprehensive child find systems: in one State, legislation is in place that provides the right to an evaluation for all children ages birth to 5 years. Children do not need to be suspected of a developmental delay to receive this evaluation. Another State has an early childhood tracking system that is effective in identification of at-risk children. Under this system, parents register, beginning at the child's birth, and complete a monthly questionnaire that, in turn, is reviewed by child development specialists. In a third State, screening activities are broadly advertised, and creative public awareness materials are used to encourage parents to attend screening activities.

OSEP identified the following areas of noncompliance in the Child Find and Public Awareness cluster:

- Part C requires States to establish a public awareness program that focuses on the early identification of eligible children and that informs the general public how to make referrals and access evaluations and services. OSEP found that public awareness programs typically are not adequate to inform the general public about the provision of early intervention services; materials are not being disseminated broadly enough to reach the general public; and materials are not appropriate or easily understood for rural parents and tribes residing on reservations. These problems exist because of lack of an ongoing, systemic campaign of public awareness activities.

- Part C requires States to implement a coordinated, comprehensive statewide child find system with all other relevant major State agencies (education, health and social services programs), and tribes and tribal organizations. OSEP found that States typically do not have State or local systems to coordinate and support a coordinated child find system to locate and identify children and not duplicate efforts unnecessarily. In addition, child find is not being coordinated with tribes and tribal organizations receiving funds under Part C. These issues are occurring, in part, due to lack of clear guidance and procedures from the State lead agency.

- States must have an effective method for primary referral sources to make referrals and to ensure that referrals are made no more than 2 working days after a child has been identified. OSEP found that many primary referral sources, including the medical community and other public and private

agencies, either do not understand the appropriate referral procedures when referring a child suspected of developmental delay and in need of early intervention services, are not aware of the early intervention system, are not referring children to the system, or the eligibility criteria prevent referral. These problems exist, in part, due to lack of effective outreach and communication methods to the medical community and public and private agencies.

- Part C requires that, within 45 days of receiving a referral, a State must ensure the completion of a comprehensive, multidisciplinary evaluation and assessment of the child's strengths and needs and identify services to meet those needs through the IFSP process. OSEP found that delays are occurring in the initial evaluation and assessment of children referred to the early intervention system and that not all required services are being identified within the 45-day timeline. Delays are occurring for a variety of reasons, including personnel shortages, lack of timely assignment of an initial service coordinator responsible for ensuring completion of the evaluation, and travel requirements to reach families residing in rural communities. OSEP also found that all required services are not being identified because the initial evaluation is not sufficiently comprehensive to identify services to meet the child's needs.

Part C: Early Intervention in Natural Environments

In creating the Part C legislation, Congress recognized the urgent need to ensure that all infants and toddlers with disabilities and their families receive early intervention services according to their individual needs. Three of the principles on which Part C was enacted include: (1) enhancing the child's developmental potential, (2) enhancing the capacity of families to meet the needs of their infant or toddler with disabilities, and (3) improving and expanding existing early intervention services being provided to children with disabilities and their families.

To assist families in this process, Congress also required that each family be provided with a service coordinator, to act as a single point of contact for the family. The service coordinator assures that the rights of children and families are provided, arranges for assessments and IFSP meetings, and facilitates the provision of needed services. The service coordinator coordinates required early intervention services, as well as medical and other services the child and the child's family may need. With a single point of contact, families are relieved of the burden of searching for essential services, negotiating with multiple agencies, and trying to coordinate their own service needs.

Part C requires the development and implementation of an IFSP for each eligible child. The evaluation, assessment, and IFSP process are designed to ensure that appropriate evaluation and assessments of the unique needs of the child and of the family related to enhancing the development of their child are conducted in a timely manner. Parents are active members of the IFSP multidisciplinary team. The team must take into consideration all the information obtained through the evaluation and child and family assessments in determining the appropriate services needed to meet the needs.

The IFSP must also include a statement of the natural environments in which early intervention services will be provided for the child. Children with disabilities should receive services in community settings and places where normally developing children would be found, so that they will not be denied opportunities that all children have to be included in all aspects of our society. In 1991, Congress required that early intervention services be provided in natural environments. This requirement was further reinforced by the addition of a new requirement in 1997 that early intervention can occur in a setting other than a natural environment only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment. In the event that early intervention cannot be satisfactorily achieved in a natural environment, the IFSP must include a justification of the extent, if any, to which the services will not be provided in a natural environment.

OSEP identified strengths in the Early Intervention Services in the Natural Environments Cluster in a number of States. Examples of promising practices that OSEP found in a variety of States include: (1) the formalized coordination of the social services, health, schools, Indian health services, and service provider agencies in each local area of a State to ensure coordinated services to infants and toddlers and their families; (2) coordination with Medicaid to institute a differential funding formula for Medicaid reimbursement for services that are conducive to providing early intervention services in homes and child care settings; and (3) development of a sophisticated system of identifying competencies and degree requirements for service coordinators, professionals, and paraprofessionals who work with infants and toddlers to ensure a holistic approach to early intervention and integration of services for this population.

In the area of noncompliance, OSEP found a variety of service coordination violations of the regulations. Not all States appoint a single service coordinator to complete all of the services coordination duties specified by the regulations, thus requiring families to continue to identify some of their own resources and services. In some States, service coordinators are not assisting families in the identification of family needs and the supports and services needed by families to address those needs, and, in cases where services for families are identified, these services are not included on the IFSP.

In some States, OSEP found that evaluations and assessments are not completed within the timeline required, and some evaluations and assessments are delayed for several weeks to several months, creating a delay in needed services. Multidisciplinary evaluations are not completed in all developmental areas, and frequently, there are not enough service providers to complete evaluations in a timely manner. OSEP found that several States are not using the IFSP process to make individual determinations for eligible children and families concerning natural environments for provision of services; some States are still providing services in segregated centers, without justification in the IFSP, where children without disabilities would not normally participate. In addition, some States do not include all the services an eligible child and family needs on the IFSP, only including those services that are available. Some States fail to include on the IFSP other non-early intervention services that the child needs, as required by Part C to make the IFSP a comprehensive document.

OSEP found that not all services listed on IFSPs were actually being provided. In some instances, services are reduced or not provided in the summer months for reasons unrelated to a child's needs. In some States, eligible children are not receiving services due to the failure of the State to provide transportation to families in need of this service. Finally, OSEP found that in several States, the IFSP team process was not being used to determine services.

Part C: Family-Centered Services

Research has shown that improved outcomes for young children are most likely to occur when services are based on the premise that parents or primary caregivers are the most important factors influencing a child's development. Family-centered practices are those in which families are involved in all aspects of the decision-making, families' culture and values are respected, and families are provided with accurate and sufficient information to be able to make informed decisions. A family-centered approach keeps the focus on the developmental needs of the child while including family concerns and needs in the decision-making process. Family-centered practices include establishing trust and rapport with families and helping families develop skills to best meet their child's needs.

Parents and other family members are recognized as the lynchpins of Part C. As such, States must include parents as an integral part of decision making and service provision, from assessments through development of the IFSP, to transition activities before their child turns 3. Parents bring a wealth of knowledge about their own child's and family's abilities and dreams for their future, as well as an understanding of the community in which they live.

In 1986, Part C of IDEA was recognized as the first Federal legislation to specifically focus attention on the needs of the family related to enhancing the development of children with disabilities. In enacting Part C, Congress acknowledged the need to support families and enhance their capacity to meet the needs of their infants and toddlers with disabilities. On the cutting edge of education legislation, Part C challenged systems of care to focus on the family as the unit of services, rather than the child. Viewing the child in the context of her/his family and the family in the context of its community, Congress created certain challenges for States as they designed and implemented a family-centered system of services.

OSEP found that States used a variety of methods to ensure and enhance family participation in the provision of early intervention services for infants and toddlers. Several states have organized and systematized programs for parent involvement, including local family liaisons, parent-to-parent support networks, programs to assist parents in navigating the system, and a program to train parents to be advocates and to participate on local and State government committees. In these States, parents assist in the development of training materials and public awareness materials. The State Interagency Coordinating Council moves its meetings to various locations around the State to allow more parents to attend and participate in the activities of the Council. These States also provide information in family friendly language and in a variety of dialects to assist families to be able to participate.

OSEP included findings related to this Cluster in the Early Intervention Services in Natural Environments section of this report.

Part C: Early Childhood Transition

Congress included provisions to ensure that preschool or other appropriate services would be provided to eligible children leaving early intervention at age 3. Transition is a multifaceted process to prepare the child and the child's family to leave early intervention services. Congress recognized the importance of coordination and cooperation between the educational agency and the early intervention system by requiring that a specific set of activities occur as part of a transition plan. Transition activities typically include: (1) identification of steps to be taken to prepare the child for changes in service delivery and to help the child adjust to a new setting, (2) preparation of the family (i.e., discussions, training, visitations), and (3) determination of other programs and services for which a child might be eligible. Transition planning for children who may be eligible for Part B preschool services must include scheduling a meeting, with approval of the family, among the lead agency, the educational agency, and the family, at least 90 days (with parental permission up to 6 months) prior to the child's third birthday. Transition of children who are not eligible for special education also includes convening a meeting to assist

families in obtaining other appropriate community-based services. For all Part C children, States must review the child's program options for the period from the child's third birthday through the remainder of the school year and must establish a transition plan.

Strengths identified during OSEP's monitoring activities in the Transition Cluster for Part C included activities leading to smooth transitions for children and families. Some States have established a committee to develop interagency plans for transition, developing local and State interagency agreements and memoranda of understanding, especially where the SEA is not the Part C lead agency. States have developed a variety of interagency training techniques for providers and parents regarding transition, including specific training for parents and joint training for staff of each agency. Transition guides have also been developed to assist parents and providers in the transition process.

OSEP also identified noncompliance issues during the monitoring visits for Part C. Some States do not hold the transition meeting at least 90 days before the child's third birthday, sometimes waiting until only a few weeks before the child turns 3. Other States do not hold a transition meeting at all for those children who are eligible for Part B or for those who will transition to community services. This practice results in failure to provide services by the child's third birthday and, in some instances, failure to provide services until the child is 4. Some States do not include transition plans in the IFSP, or, for transition planning, the IFSP only states that the child will transition, without the appropriate steps to prepare the child and the child's family for transition out of Part C.

Part B: Parent Involvement

A purpose of the IDEA Amendments of 1997 is to expand and promote opportunities for parents and school personnel to work in new partnerships at the State and local levels. Parents must now have an opportunity to participate in meetings with respect to the identification, evaluation, and educational placement of their child and the provision of a free appropriate public education to their child. Parental involvement has long been recognized as an important indicator of a school's success, and parent involvement has positive effects on children's attitudes and social behavior. Partnerships positively affect achievement, improve parents' attitudes toward the school, and benefit school personnel as well.

With the enactment of the IDEA Amendments of 1997, OSEP's work in shaping its accountability in a way that drives and supports improved results for infants, toddlers, children, and youth with disabilities intensified. In order to ensure compliance with the amendments, which support positive results for people with

disabilities, OSEP designed a multifaceted process. Among the Part B requirements that provide the strongest links to improved educational results for students with disabilities are those addressing the participation of parents and students and general and special education personnel in the development and implementation of educational programs for children with disabilities. One of the four major areas in which Part B requirements are clustered for children ages 3 through 21 is parent involvement.

Since the enactment of the IDEA Amendments of 1997, OSEP has identified specific strengths in the Part B Parent Involvement Cluster in a number of States. OSEP's review of States using its new continuous monitoring process found the following examples of these promising practices: (1) joint training in some States where States and parent groups collaborate with Parent Training and Information Centers on the 1997 amendments, (2) jointly developed training materials for use by parents and personnel, and (3) the successful use of mediation as a process for conflict resolution where parents report that they feel heard and valued as partners in mediation. In a number of instances, OSEP found that parents and communities provide strong support to the educational process, with families very involved in the educational programs for their children and, reciprocally, the schools actively involving parents in meetings concerning their child's special education.

Issues of noncompliance identified by OSEP include findings that in some States, parents are not part of the group that reviews existing evaluation data to determine whether a child has a disability. In these cases, parents are also not part of the reevaluation process to determine whether the child continues to have a specific disability, and parents are not included on the multidisciplinary team that makes the placement decision for the child.

Part B: Free Appropriate Public Education in the Least Restrictive Environment

The provision of a free appropriate public education in the least restrictive environment is the foundation of IDEA. The provisions of the statute and regulations (evaluation, individualized education program (IEP), parent and student involvement, transition, participation in large-scale assessment, eligibility and placement decisions, service provision, etc.) exist to achieve this single purpose. It means that children with disabilities receive educational services at no cost to their parents and that the services provided meet their unique learning needs. These services are provided, to the maximum extent appropriate, with children who do not have disabilities and, unless their IEP requires some other arrangement, in the school they would attend if they did not have a disability. Any removal of children with disabilities from the regular educational environment occurs only when the nature or

severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

The Committee Reports of the Senate Committee on Labor and Human Resources and the House of Representatives Committee on Education and the Workforce for the 1997 amendments emphasized that too many students with disabilities are failing courses and dropping out of school. Those reports noted that almost twice as many children with disabilities drop out as compared to children without disabilities. They expressed a further concern about the continued inappropriate placement of children from minority backgrounds and children with limited English proficiency in special education. The Committees stated their intention that "once a child has been identified as being eligible for special education, the connection between special education and related services and the child's opportunity to experience and benefit from the general education curriculum should be strengthened. The majority of children identified as eligible for special education and related services are capable of participating in the general education curriculum to varying degrees with some adaptations and modifications. This provision is intended to ensure that children's special education and related services are in addition to and are affected by the general education curriculum, not separate from it."

OSEP identified strengths in the Free Appropriate Public Education in the Least Restrictive Environment Cluster in a number of States. Several States were commended for the activities they had developed to ensure that appropriately trained administrators, teachers, paraprofessionals, and related services personnel are located and available to meet the identified needs of all children with disabilities. Efforts taken to retain personnel after they have been hired were also recognized. Examples of these activities include the creation of a recruitment website to assist local districts in locating qualified personnel, upgrading of the special education teacher certification requirements, development of minimum competencies for paraprofessionals, and the development of unique approaches to secure qualified staff in rural areas. Other examples of staff development include the creation of an inclusive education training project for school districts to assist them in initiating and implementing inclusive educational practices and the development of an educational interpreter certificate project which utilizes distance learning and summer programs to deliver instruction to educational interpreters. In one State, new endorsement requirements were implemented for teachers who had requested endorsement for birth through age 8 programs that would require coursework focusing on the unique needs of students within this age range.

Particularly noteworthy were the initiatives taken by some States to address the needs of students with behavioral disorders. The creation of statewide projects and other mechanisms, such as the use of assessment instruments, to provide comprehensive

staff development to improve the capacities of schools and communities are among the initiatives taken to address the needs of this population.

A few States were recognized for the steps taken to address the needs of students from birth to age 9. One State expanded the developmental delay category to age 9, giving school districts the option of providing services to younger children without having to lock the child into an eligibility category which may be inappropriate or incorrect. Another State increased the size of the State staff responsible for providing linkages to other State level transition services for young children and their families.

Other strengths which demonstrate the variety of State-level initiatives for providing a free appropriate public education in the least restrictive environment include the following:

- Data gathering instruments, such as the development of a single State-level student information management system to collect data across programs and the development of a system that allows the State to collaborate between various programs to collect suspension/expulsion data for all students, including students with disabilities;

- Close working relationships with the State Advisory Panel to formulate policy and guidance for implementing the 1997 amendments;

- Creation of a financial safety net in the special education funding formula to ensure that all eligible children and youth with disabilities receive a free appropriate public education by providing State funds for students requiring high-cost services and to districts receiving less State special education revenue than the previous year;

- Proactive steps to increase the involvement of children with disabilities in state- and district-wide assessment programs.

The areas of noncompliance that OSEP identified within the Free Appropriate Public Education in the Least Restrictive Environment Cluster focused on requirements in the following areas:

- Removal of children from regular education settings only when the nature and severity of disability is such that education in regular classes, with the use of supplementary aides and supports, cannot be achieved satisfactorily.

Lack of supplementary aids and services, inadequate number of appropriately trained staff, and an inadequate supply of qualified staff are factors that affect decisions about removal of students from regular education classes. Students with emotional disturbance or intellectual or multiple disabilities tend to be inappropriately placed in segregated classes most often. In some instances, placement decisions continue to be based on the intensity of service level and disability category rather than on the unique needs of the child.

- Transition from Part C to B.

  Some States did not consistently ensure that public agencies carry out a smooth and effective transition to Part B services. For example, collaboration among local staff is limited, and communication often results in philosophical disagreements about evaluations, untimely or no transition meetings, and inappropriate breaks in services for young children. In some cases, school staff does not consistently participate when invited to transition planning meetings. In other instances, transition for all children occurs at the beginning of the school year, regardless of the child's birthday, resulting in some children not receiving their needed services until after they turn 3 years of age.

- Extended school year services.

  Students in some States are not receiving extended school year services, in accordance with an appropriate IEP. This violation seems to be related to a lack of understanding about this requirement and a need for additional training about the process and criteria for receiving extended school year services.

- Qualified staff to provide special education and related services.

  States did not consistently ensure that public agencies have an adequate supply of qualified special education and related-services personnel necessary to carry out the purposes of IDEA. This is especially true with teachers qualified to serve students with severe behavior disorders, as well as related-service providers such as speech therapists, physical therapists, occupational therapists, and individuals qualified to provide psychological counseling. These shortages result in students not receiving needed services; delays in the provision of services; failure to provide students access to the general education curriculum due to lack of supports, including behavioral supports; provision of poor-quality services because services are provided by unqualified and untrained staff; provision of services on a consultative base in order to "stretch" staff availability; and discontinuance of direct services to allow time for conducting evaluation.

- Related services--psychological counseling.

  Findings related to the provision of psychological counseling indicated that the type and amount of these services are limited in that they are often based on the category of disability or the grade level, rather than on the individual needs of the child. In some cases, parents pay for these services even when they are determined necessary by the IEP team for the child to benefit from special education. When psychological counseling is provided by an outside agency, it is rarely integrated into the student's IEP.

Part B: Secondary Transition

The National Longitudinal Transition Study found that the rate of competitive employment for youth with disabilities out of school for 3 to 5 years was 57 percent, compared to an employment rate of 60 percent for youth in the general population. The study identified several factors that were associated with post-school success in obtaining employment and earning higher wages for youth with disabilities. These include completing high school, spending more time in regular education, and taking vocational education in secondary school. The study also shows that post-school success is associated with youths who had a transition plan in high school that specified an outcome, such as employment, as a goal. The secondary transition requirements of IDEA focus on the active involvement of students in transition planning, consideration of student's preferences and interests by the IEP team, and the reflection, in the IEP, of a coordinated set of activities within an outcome-oriented process which promotes movement from school to post-school activities. Through parent and student involvement, along with the involvement of all agencies that can provide transition services, student needs can be appropriately identified and services provided that best meet those needs.

Strengths identified by OSEP in the Secondary Transition Cluster in a number of States include: (1) State education agency (SEA) funding of transition coordinator positions; (2) increased interagency collaboration with other agencies likely to provide transition-related services, including the local vocational rehabilitation agency; (3) partnerships with industry and school-to-work initiatives; (4) development of State Transition Coordinating Councils and Transition Task Forces to address transition from secondary to postsecondary education; (5) SEA grants to expand self-advocacy, job training, and postsecondary program admission; (6) an SEA follow-up longitudinal study; and (7) linkages with institutions of higher education.

Consistent with monitoring findings from previous years, OSEP found that in some States, there seems to be little movement in resolving noncompliance in the

following areas: (1) lack of student and other agency participation in the development of transition plans due to the failure of the local education agency to invite and ensure participation of the student and other agency representatives; (2) failure to consistently notify parents regarding the IEP meeting for which the purpose is the discussion of transition services, causing parents to be unprepared to discuss transition needs and options at the meeting; (3) lack of statements for students, beginning at age 14, of needed transition services to begin at age 16 (or younger if determined appropriate by the IEP team); and (4) a lack of understanding of the transition requirements, specifically interests and preferences of the student, related services, and course of study.

In addition to these areas of noncompliance, OSEP also identified suggestions for improved results, including determination of appropriate agency linkages; development of interagency agreements/memoranda of understanding; increased collaboration with other agencies; provision of training on the implementation of transition requirements to parents, students, and service providers; increased understanding of, involvement in, and availability of independent living centers; increased availability of community experience of Native American students residing on reservations; and the development of culturally sensitive transition plans to meet the needs of these students.

Part B: General Supervision

IDEA assigns responsibility to SEAs for ensuring that its requirements are met and that all educational programs for children with disabilities, including all such programs administered by any other State or local agency, are under the general supervision of individuals in the State who are responsible for educational programs for children with disabilities and that these programs meet the educational standards of the SEA. State support and involvement at the local level are critical to the successful implementation of the provisions of IDEA. To carry out their responsibilities, States provide dispute resolution mechanisms (mediation, complaint resolution, and due process), monitor the implementation of Federal and State statutes and regulations, establish standards for personnel development and certification as well as educational programs, and provide technical assistance and training across the State. Effective general supervision promotes positive student outcomes by promoting appropriate educational services to children with disabilities, ensuring the successful and timely correction of identified deficiencies, and providing personnel who work with children with disabilities the knowledge, skills, and abilities necessary to carry out their assigned responsibilities.

OSEP identified strengths in the General Supervision Cluster in a number of States. Examples of promising practices include statewide training opportunities through

the SEA, the establishment of interagency collaboration to benefit children and families, intervention through an early assistance program to intervene in disputes prior to filing a complaint or due process hearing, a regionalized personnel development system, school district accountability for results for children with disabilities, access to a "safety net" fund that may be utilized by school districts to offset high special education costs, and a data collection system on LEAs that can provide a wide array of information.

OSEP also identified noncompliance in the General Supervision Cluster in States that were monitored. Examples of noncompliance include the SEA not ensuring that school-aged incarcerated individuals with disabilities are identified and provided special education services, a monitoring system that was ineffective in identifying and correcting noncompliance in some public agencies, and the completion of due process hearings outside the required 45-day timeline.

References

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APPENDIX A

DATA TABLES

This Appendix includes a compilation and analysis of data gathered on children with disabilities served under IDEA and reference data on all school-aged children. As required by IDEA, the Part B data tables include child count (1998-99), placement (1997-98), personnel (1997-98), and exiting (1997-98). Data on infants and toddlers served in accord with IDEA, Part C are also included. Finally, data on estimated resident population for children ages 3 through 21, total enrollment for students in pre-kindergarten through 12th grade, and State grant awards under IDEA are provided.

Table AA1

Number of Children Served Under IDEA, Part B by Age Group

During the 1998-99 School Year

STATE	AGE GROUP					
	3-5	6-11	12-17	6-17	18-21	3-21
ALABAMA	7,499	44,384	42,337	86,721	5,593	99,813
ALASKA	1,754	8,341	6,896	15,237	721	17,712
ARIZONA	8,876	41,662	34,343	76,005	3,717	88,598
ARKANSAS	8,677	23,458	24,310	47,768	2,665	59,110
CALIFORNIA	56,837	288,947	253,221	542,168	24,646	623,651
COLORADO	7,814	32,763	31,280	64,043	3,277	75,134
CONNECTICUT	7,443	32,881	32,893	65,774	3,523	76,740
DELAWARE	1,664	7,884	6,060	13,944	625	16,233
DISTRICT OF COLUMBIA	409	3,440	3,710	7,150	603	8,162
FLORIDA	28,233	165,705	137,265	302,970	13,968	345,171
GEORGIA	15,134	78,449	57,399	135,848	4,772	155,754
HAWAII	1,646	9,199	9,023	18,222	683	20,551
IDAHO	3,466	12,849	10,276	23,125	962	27,553
ILLINOIS	27,524	131,192	113,748	244,940	11,234	283,698
INDIANA	13,778	70,759	55,605	126,364	6,417	146,559
IOWA	5,578	30,188	31,617	61,805	3,575	70,958
KANSAS	6,933	25,703	23,283	48,986	2,506	58,425
KENTUCKY	15,161	39,292	30,144	69,436	3,376	87,973
LOUISIANA	9,495	40,199	40,349	80,548	5,202	95,245
MAINE	3,690	14,787	14,246	29,033	1,571	34,294
MARYLAND	9,714	51,569	46,251	97,820	4,154	111,688
MASSACHUSETTS	15,382	72,753	72,240	144,993	8,589	168,964
MICHIGAN	18,983	94,387	84,509	178,896	10,524	208,403
MINNESOTA	11,327	45,649	44,841	90,490	4,377	106,194
MISSISSIPPI	6,046	27,755	25,059	52,814	2,918	61,778
MISSOURI	9,698	59,844	56,002	115,846	6,021	131,565
MONTANA	1,688	8,323	7,948	16,271	838	18,797
NEBRASKA	3,656	19,614	17,675	37,289	2,455	43,400
NEVADA	3,531	15,585	13,187	28,772	1,016	33,319
NEW HAMPSHIRE	2,190	11,411	12,467	23,878	1,434	27,502
NEW JERSEY	15,998	100,989	83,228	184,217	9,899	210,114
NEW MEXICO	5,133	21,755	22,958	44,713	2,267	52,113
NEW YORK	50,616	176,431	181,245	357,676	23,827	432,119
NORTH CAROLINA	16,880	82,127	61,134	143,261	5,192	165,333
NORTH DAKOTA	1,197	5,840	5,472	11,312	672	13,181
OHIO	18,572	101,583	96,411	197,994	13,589	230,155
OKLAHOMA	5,805	36,309	34,182	70,491	3,993	80,289
OREGON	6,128	33,373	27,599	60,972	2,819	69,919
PENNSYLVANIA	19,652	97,583	96,789	194,372	12,356	226,378
PUERTO RICO	5,559	23,604	21,747	45,351	3,248	54,158
RHODE ISLAND	2,510	13,004	11,127	24,131	1,270	27,911
SOUTH CAROLINA	10,937	50,216	34,435	84,651	3,445	99,033
SOUTH DAKOTA	2,164	7,546	5,309	12,855	683	15,702
TENNESSEE	10,291	57,538	53,477	111,015	6,967	128,273
TEXAS	34,846	210,056	216,191	426,247	25,656	486,749
UTAH	5,710	25,627	21,451	47,078	2,464	55,252
VERMONT	1,226	5,021	5,813	10,834	649	12,709
VIRGINIA	13,713	69,200	64,064	133,264	6,739	153,716
WASHINGTON	11,799	53,276	44,165	97,441	4,904	114,144
WEST VIRGINIA	5,301	22,775	19,367	42,142	2,491	49,934
WISCONSIN	13,708	49,269	47,789	97,058	5,562	116,328
WYOMING	1,616	5,544	5,439	10,983	734	13,333
AMERICAN SAMOA	58	268	242	510	16	584
GUAM	156	828	926	1,754	165	2,075
NORTHERN MARIANAS	51	177	199	376	47	474
PALAU	5	34	68	102	5	112
VIRGIN ISLANDS	180	630	844	1,474	117	1,771
BUR. OF INDIAN AFFAIRS	0	0	0	0	0	0
U.S. AND OUTLYING AREAS	573,637	2,759,575	2,499,855	5,259,430	281,736	6,114,803
50 STATES, D.C. & P.R.	573,187	2,757,638	2,497,576	5,255,214	281,386	6,109,787

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AA7

Number of Students Ages 3-5 Served Under IDEA, Part B by Race/Ethnicity

During the 1998-99 School Year

STATE	AMERICAN INDIAN/ ALASKAN	ASIAN/ PACIFIC ISLANDER	BLACK	HISPANIC	WHITE	DISCREPANCY WITH CHILD COUNT
ALABAMA	14	21	2,917	28	4,498	21
ALASKA	519	64	101	54	1,016	0
ARIZONA	644	101	422	2,703	5,006	0
ARKANSAS	21	83	2,492	137	5,944	0
CALIFORNIA	441	3,158	5,644	22,431	25,163	0
COLORADO	80	140	444	1,523	5,627	0
CONNECTICUT	34	86	922	1,006	5,395	0
DELAWARE	2	9	457	83	1,113	0
DISTRICT OF COLUMBIA	0	0	369	14	26	0
FLORIDA	.	.	.	.	.	.
GEORGIA	23	127	5,349	374	9,261	0
HAWAII	12	1,161	56	58	359	0
IDAHO	34	13	29	374	3,018	-2
ILLINOIS	16	284	4,265	1,926	21,003	30
INDIANA	21	52	1,177	241	12,287	0
IOWA	25	41	212	122	5,178	0
KANSAS	69	54	588	502	5,720	0
KENTUCKY	6	50	1,572	87	13,446	0
LOUISIANA	39	33	4,356	71	4,996	0
MAINE	13	19	36	30	3,592	0
MARYLAND	31	229	3,201	317	5,936	0
MASSACHUSETTS	31	200	1,538	1,554	12,059	0
MICHIGAN	129	561	3,039	389	14,865	0
MINNESOTA	289	231	770	330	9,707	0
MISSISSIPPI	4	5	2,567	14	3,456	0
MISSOURI	17	45	1,359	125	8,152	0
MONTANA	234	14	14	17	1,409	0
NEBRASKA	78	35	256	234	3,053	0
NEVADA	106	92	410	649	2,274	0
NEW HAMPSHIRE	3	9	5	22	2,151	0
NEW JERSEY	15	510	2,476	1,997	11,000	0
NEW MEXICO	664	27	111	2,440	1,891	0
NEW YORK	292	965	6,088	5,872	19,717	17,682
NORTH CAROLINA	343	82	5,856	343	10,256	0
NORTH DAKOTA	101	13	12	18	1,053	0
OHIO	24	96	2,439	262	15,751	0
OKLAHOMA	920	41	553	201	4,090	0
OREGON	107	101	132	569	5,219	0
PENNSYLVANIA	31	172	2,729	765	15,955	0
PUERTO RICO	5	4	0	5,550	0	0
RHODE ISLAND	3	15	129	265	2,098	0
SOUTH CAROLINA	7	25	5,342	88	5,475	0
SOUTH DAKOTA	355	18	49	36	1,706	0
TENNESSEE	10	55	1,810	101	8,315	0
TEXAS	105	465	4,311	11,123	18,842	0
UTAH	186	65	55	369	5,035	0
VERMONT	4	8	12	2	1,200	0
VIRGINIA	44	226	3,270	693	9,480	0
WASHINGTON	408	447	688	1,426	8,930	0
WEST VIRGINIA	1	15	161	8	5,116	0
WISCONSIN	171	155	1,728	474	11,180	0
WYOMING	73	8	19	127	1,389	0
AMERICAN SAMOA	0	58	0	0	0	0
GUAM	4	130	14	0	8	0
NORTHERN MARIANAS	0	51	0	0	0	0
PALAU	0	5	0	0	0	0
VIRGIN ISLANDS	.	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	6,808	10,674	82,551	68,144	359,316	46,144
50 STATES, D.C. & P.R.	6,804	10,430	82,537	68,144	359,308	45,964

Data based on the December 1, 1998 count, updated as of November 1, 1999.

A minus in the last column indicates the counts for race/ethnicity exceeded the total count for children served.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AA7

Percentage of Students Ages 3-5 Served Under IDEA, Part B by Race/Ethnicity During the 1998-99 School Year

STATE	AMERICAN INDIAN/ ALASKAN	ASIAN/ PACIFIC ISLANDER	BLACK	HISPANIC	WHITE
ALABAMA	0.19	0.28	39.01	0.37	60.15
ALASKA	29.59	3.65	5.76	3.08	57.92
ARIZONA	7.26	1.14	4.75	30.45	56.40
ARKANSAS	0.24	0.96	28.72	1.58	68.50
CALIFORNIA	0.78	5.56	9.93	39.47	44.27
COLORADO	1.02	1.79	5.68	19.49	72.01
CONNECTICUT	0.46	1.16	12.39	13.52	72.48
DELAWARE	0.12	0.54	27.46	4.99	66.89
DISTRICT OF COLUMBIA	0.00	0.00	90.22	3.42	6.36
FLORIDA	.	.	.	.	.
GEORGIA	0.15	0.84	35.34	2.47	61.19
HAWAII	0.73	70.53	3.40	3.52	21.81
IDAHO	0.98	0.37	0.84	10.78	87.02
ILLINOIS	0.06	1.03	15.51	7.01	76.39
INDIANA	0.15	0.38	8.54	1.75	89.18
IOWA	0.45	0.74	3.80	2.19	92.83
KANSAS	1.00	0.78	8.48	7.24	82.50
KENTUCKY	0.04	0.33	10.37	0.57	88.69
LOUISIANA	0.41	0.35	45.88	0.75	52.62
MAINE	0.35	0.51	0.98	0.81	97.34
MARYLAND	0.32	2.36	32.95	3.26	61.11
MASSACHUSETTS	0.20	1.30	10.00	10.10	78.40
MICHIGAN	0.68	2.96	16.01	2.05	78.31
MINNESOTA	2.55	2.04	6.80	2.91	85.70
MISSISSIPPI	0.07	0.08	42.46	0.23	57.16
MISSOURI	0.18	0.46	14.01	1.29	84.06
MONTANA	13.86	0.83	0.83	1.01	83.47
NEBRASKA	2.13	0.96	7.00	6.40	83.51
NEVADA	3.00	2.61	11.61	18.38	64.40
NEW HAMPSHIRE	0.14	0.41	0.23	1.00	98.22
NEW JERSEY	0.09	3.19	15.48	12.48	68.76
NEW MEXICO	12.94	0.53	2.16	47.54	36.84
NEW YORK	0.89	2.93	18.49	17.83	59.87
NORTH CAROLINA	2.03	0.49	34.69	2.03	60.76
NORTH DAKOTA	8.44	1.09	1.00	1.50	87.97
OHIO	0.13	0.52	13.13	1.41	84.81
OKLAHOMA	15.85	0.71	9.53	3.46	70.46
OREGON	1.75	1.65	2.15	9.29	85.17
PENNSYLVANIA	0.16	0.88	13.89	3.89	81.19
PUERTO RICO	0.09	0.07	0.00	99.84	0.00
RHODE ISLAND	0.12	0.60	5.14	10.56	83.59
SOUTH CAROLINA	0.06	0.23	48.84	0.80	50.06
SOUTH DAKOTA	16.40	0.83	2.26	1.66	78.84
TENNESSEE	0.10	0.53	17.59	0.98	80.80
TEXAS	0.30	1.33	12.37	31.92	54.07
UTAH	3.26	1.14	0.96	6.46	88.18
VERMONT	0.33	0.65	0.98	0.16	97.88
VIRGINIA	0.32	1.65	23.85	5.05	69.13
WASHINGTON	3.46	3.79	5.83	12.09	74.84
WEST VIRGINIA	0.02	0.28	3.04	0.15	96.51
WISCONSIN	1.25	1.13	12.61	3.46	81.56
WYOMING	4.52	0.50	1.18	7.86	85.95
AMERICAN SAMOA	0.00	100.00	0.00	0.00	0.00
GUAM	2.56	83.33	8.97	0.00	5.13
NORTHERN MARIANAS	0.00	100.00	0.00	0.00	0.00
PALAU	0.00	100.00	0.00	0.00	0.00
VIRGIN ISLANDS	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
U.S. AND OUTLYING AREAS	1.29	2.02	15.65	12.92	68.12
50 STATES, D.C. & P.R.	1.29	1.98	15.66	12.93	68.15

Percentages are based on the counts of children with disabilities ages 3-5 for whom race/ethnicity were provided.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AA8

Number of Children Served Under IDEA, Part B by Disability and Age

During the 1998-99 School Year

DISABILITY	3 YEARS OLD	4 YEARS OLD	5 YEARS OLD	6 YEARS OLD	7 YEARS OLD	8 YEARS OLD	9 YEARS OLD
SPECIFIC LEARNING DISABILITIES	.	.	.	38,252	90,766	168,803	241,006
SPEECH OR LANGUAGE IMPAIRMENTS	.	.	.	212,532	212,846	193,746	149,993
MENTAL RETARDATION	.	.	.	22,525	31,190	40,465	46,123
EMOTIONAL DISTURBANCE	.	.	.	9,177	16,496	24,465	31,184
MULTIPLE DISABILITIES	.	.	.	7,623	7,364	8,304	8,796
HEARING IMPAIRMENTS	.	.	.	4,407	5,157	5,744	5,966
ORTHOPEDIC IMPAIRMENTS	.	.	.	5,712	6,093	6,224	6,322
OTHER HEALTH IMPAIRMENTS	.	.	.	10,075	13,924	18,810	21,747
VISUAL IMPAIRMENTS	.	.	.	1,718	1,886	2,224	2,128
AUTISM	.	.	.	7,677	6,839	6,202	5,316
DEAF-BLINDNESS	.	.	.	97	101	127	118
TRAUMATIC BRAIN INJURY	.	.	.	444	612	812	953
DEVELOPMENTAL DELAY	.	.	.	6,355	3,361	1,842	352
ALL DISABILITIES	117,698	199,924	256,015	326,594	396,635	477,768	520,004

DISABILITY	10 YEARS OLD	11 YEARS OLD	12 YEARS OLD	13 YEARS OLD	14 YEARS OLD	15 YEARS OLD	16 YEARS OLD
SPECIFIC LEARNING DISABILITIES	282,988	298,810	300,946	294,412	275,091	258,149	231,343
SPEECH OR LANGUAGE IMPAIRMENTS	108,009	69,970	43,042	29,326	19,298	13,536	10,231
MENTAL RETARDATION	49,184	51,009	52,674	53,296	52,362	51,981	49,458
EMOTIONAL DISTURBANCE	36,113	39,937	44,332	48,523	50,374	51,258	47,907
MULTIPLE DISABILITIES	8,844	8,673	7,872	7,779	7,389	7,328	7,268
HEARING IMPAIRMENTS	6,169	6,223	5,849	5,819	5,374	5,302	5,122
ORTHOPEDIC IMPAIRMENTS	5,982	5,711	5,557	5,382	5,090	4,718	4,417
OTHER HEALTH IMPAIRMENTS	23,054	22,685	21,093	19,972	18,148	16,683	14,872
VISUAL IMPAIRMENTS	2,103	2,076	2,100	1,975	2,041	2,052	2,036
AUTISM	4,654	4,109	3,406	3,078	2,563	2,460	2,099
DEAF-BLINDNESS	99	104	110	120	122	122	137
TRAUMATIC BRAIN INJURY	1,016	1,052	1,029	1,112	1,040	1,099	1,135
DEVELOPMENTAL DELAY	.	.	.	.	.	.	.
ALL DISABILITIES	528,215	510,359	488,010	470,794	438,892	414,686	376,025

DISABILITY	17 YEARS OLD	18 YEARS OLD	19 YEARS OLD	20 YEARS OLD	21 YEARS OLD	22 YEARS OLD
SPECIFIC LEARNING DISABILITIES	191,926	112,589	24,738	5,632	1,697	135
SPEECH OR LANGUAGE IMPAIRMENTS	7,228	3,587	828	275	101	22
MENTAL RETARDATION	43,549	33,690	17,210	10,793	5,567	1,979
EMOTIONAL DISTURBANCE	37,158	18,241	5,296	2,074	727	119
MULTIPLE DISABILITIES	6,476	5,290	4,023	3,029	1,705	454
HEARING IMPAIRMENTS	4,777	3,185	1,159	451	179	25
ORTHOPEDIC IMPAIRMENTS	3,723	2,429	1,104	647	384	120
OTHER HEALTH IMPAIRMENTS	11,825	5,688	1,535	526	194	12
VISUAL IMPAIRMENTS	1,787	1,124	510	258	114	23
AUTISM	1,755	1,373	966	730	349	224
DEAF-BLINDNESS	107	102	61	45	37	3
TRAUMATIC BRAIN INJURY	1,135	822	368	210	94	3
DEVELOPMENTAL DELAY	.	.	.	.	.	.
ALL DISABILITIES	311,446	188,120	57,798	24,670	11,148	3,119

Please see data notes for an explanation of individual State differences.

Developmental Delay is applicable only to children 3 through 9.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AA9

Number of Children Served Under IDEA, Part B by Age

During the 1998-99 School Year

All Disabilities

STATE	3 YEARS OLD	4 YEARS OLD	5 YEARS OLD	6 YEARS OLD	7 YEARS OLD	8 YEARS OLD
ALABAMA	1,148	2,295	4,056	5,424	6,196	7,755
ALASKA	345	618	791	932	1,186	1,546
ARIZONA	1,773	3,306	3,797	4,636	5,553	7,077
ARKANSAS	2,120	3,594	2,963	3,215	3,428	3,974
CALIFORNIA	11,996	20,953	23,888	30,841	40,035	50,685
COLORADO	1,579	2,936	3,299	3,658	4,592	5,625
CONNECTICUT	1,706	2,709	3,028	3,405	4,433	5,553
DELAWARE	352	552	760	967	1,273	1,437
DISTRICT OF COLUMBIA	70	168	171	225	401	590
FLORIDA	5,511	8,660	14,062	19,208	24,030	29,124
GEORGIA	2,474	5,010	7,650	10,182	12,247	13,605
HAWAII	357	543	746	1,090	1,277	1,595
IDAHO	736	1,267	1,463	1,591	1,978	2,330
ILLINOIS	5,006	9,346	13,172	16,683	20,694	23,412
INDIANA	2,797	4,462	6,519	8,770	11,386	13,423
IOWA	1,041	1,911	2,626	3,337	4,125	5,175
KANSAS	1,574	2,471	2,888	3,230	3,490	4,563
KENTUCKY	3,065	5,688	6,408	6,217	6,350	6,426
LOUISIANA	1,592	3,211	4,692	5,502	6,308	6,782
MAINE	823	1,503	1,364	1,680	2,184	2,476
MARYLAND	2,020	3,294	4,400	5,899	7,077	8,494
MASSACHUSETTS	3,779	5,939	5,664	8,018	10,193	12,489
MICHIGAN	3,983	6,213	8,787	10,916	13,152	16,551
MINNESOTA	2,537	4,050	4,740	5,154	6,114	7,728
MISSISSIPPI	663	1,651	3,732	4,974	5,038	4,641
MISSOURI	1,922	3,468	4,308	5,736	8,074	10,648
MONTANA	310	557	821	961	1,214	1,563
NEBRASKA	855	1,250	1,551	1,914	2,653	3,538
NEVADA	685	1,375	1,471	1,681	2,086	2,748
NEW HAMPSHIRE	501	791	898	1,103	1,433	1,837
NEW JERSEY	3,006	4,407	8,585	14,048	17,101	18,552
NEW MEXICO	1,171	1,976	1,986	2,278	2,970	3,636
NEW YORK	14,294	20,196	16,126	21,626	21,703	28,086
NORTH CAROLINA	3,141	5,429	8,310	10,669	12,620	13,950
NORTH DAKOTA	212	396	589	741	914	1,005
OHIO	3,429	5,979	9,164	11,333	14,680	17,914
OKLAHOMA	1,115	1,967	2,723	3,931	5,004	6,297
OREGON	1,505	2,267	2,356	2,994	4,304	5,874
PENNSYLVANIA	4,476	7,518	7,658	9,795	13,207	17,248
PUERTO RICO	1,086	2,153	2,320	2,795	3,417	4,195
RHODE ISLAND	476	877	1,157	1,593	1,922	2,293
SOUTH CAROLINA	1,373	3,370	6,194	7,259	8,333	8,771
SOUTH DAKOTA	414	738	1,012	1,084	1,187	1,437
TENNESSEE	1,591	3,067	5,633	7,744	8,967	10,008
TEXAS	6,113	11,363	17,370	22,612	27,556	34,286
UTAH	1,408	2,040	2,262	2,868	4,009	4,897
VERMONT	272	401	553	535	603	852
VIRGINIA	2,701	4,631	6,381	8,738	10,213	11,868
WASHINGTON	2,365	4,082	5,352	5,979	7,403	9,501
WEST VIRGINIA	903	1,640	2,758	3,228	3,759	4,038
WISCONSIN	2,818	4,802	6,088	6,756	7,489	8,439
WYOMING	388	673	555	605	845	990
AMERICAN SAMOA	13	24	21	12	28	29
GUAM	58	45	53	80	95	99
NORTHERN MARIANAS	6	19	26	22	17	24
PALAU	3	1	1	6	3	2
VIRGIN ISLANDS	41	72	67	114	86	87
BUR. OF INDIAN AFFAIRS	0	0	0	0	0	0
U.S. AND OUTLYING AREAS	117,698	199,924	256,015	326,594	396,635	477,768
50 STATES, D.C. & P.R.	117,577	199,763	255,847	326,360	396,406	477,527

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AA9

Number of Children Served Under IDEA, Part B by Age

During the 1998-99 School Year

All Disabilities

STATE	9 YEARS OLD	10 YEARS OLD	11 YEARS OLD	12 YEARS OLD	13 YEARS OLD	14 YEARS OLD
ALABAMA	8,179	8,606	8,224	8,064	7,756	7,477
ALASKA	1,661	1,574	1,442	1,391	1,359	1,266
ARIZONA	7,991	8,264	8,141	7,496	7,018	6,185
ARKANSAS	4,141	4,355	4,345	4,337	4,383	4,284
CALIFORNIA	55,177	57,126	55,083	52,097	49,063	43,984
COLORADO	6,178	6,377	6,333	6,241	5,883	5,603
CONNECTICUT	6,258	6,686	6,546	6,336	6,271	5,724
DELAWARE	1,493	1,384	1,330	1,224	1,154	1,087
DISTRICT OF COLUMBIA	733	751	740	732	692	665
FLORIDA	31,233	32,154	29,956	28,277	26,953	24,469
GEORGIA	14,471	14,438	13,506	12,731	12,016	10,516
HAWAII	1,766	1,820	1,651	1,710	1,629	1,561
IDAHO	2,435	2,323	2,192	2,165	2,027	1,888
ILLINOIS	24,245	23,650	22,508	22,094	21,293	19,933
INDIANA	13,225	12,506	11,449	10,474	10,360	9,827
IOWA	5,805	5,901	5,845	5,847	5,828	5,612
KANSAS	4,923	4,892	4,605	4,466	4,359	4,133
KENTUCKY	6,707	6,849	6,743	6,367	5,821	5,239
LOUISIANA	7,119	7,190	7,298	7,316	7,440	7,380
MAINE	2,779	2,847	2,821	2,827	2,755	2,452
MARYLAND	9,937	10,215	9,947	9,363	9,207	8,138
MASSACHUSETTS	13,962	14,082	14,009	13,532	13,303	12,499
MICHIGAN	18,242	17,901	17,625	16,635	16,349	15,329
MINNESOTA	8,875	9,181	8,597	8,662	8,428	7,834
MISSISSIPPI	4,446	4,402	4,254	4,332	4,552	4,414
MISSOURI	11,961	11,978	11,447	11,054	11,011	10,003
MONTANA	1,555	1,512	1,518	1,433	1,517	1,424
NEBRASKA	4,003	3,814	3,692	3,505	3,391	3,127
NEVADA	3,120	3,182	2,768	2,705	2,556	2,315
NEW HAMPSHIRE	2,231	2,405	2,402	2,444	2,323	2,119
NEW JERSEY	17,880	17,122	16,286	15,285	14,884	14,129
NEW MEXICO	4,050	4,353	4,468	4,474	4,447	4,145
NEW YORK	34,366	34,742	35,908	32,681	31,762	31,751
NORTH CAROLINA	15,203	15,499	14,186	13,468	12,395	11,411
NORTH DAKOTA	1,076	1,051	1,053	1,047	1,056	907
OHIO	19,317	19,692	18,647	18,139	17,439	16,704
OKLAHOMA	7,129	7,200	6,748	6,579	6,296	5,948
OREGON	6,903	6,922	6,376	5,907	5,587	4,932
PENNSYLVANIA	19,348	19,600	18,385	17,792	17,118	16,526
PUERTO RICO	4,300	4,470	4,427	4,345	4,068	3,896
RHODE ISLAND	2,385	2,459	2,352	2,143	2,091	1,826
SOUTH CAROLINA	9,060	8,856	7,937	7,228	6,827	6,101
SOUTH DAKOTA	1,439	1,270	1,129	1,045	993	960
TENNESSEE	10,301	10,419	10,099	9,822	9,835	9,100
TEXAS	39,291	42,831	43,480	41,964	39,829	37,310
UTAH	4,808	4,674	4,371	4,048	3,848	3,777
VERMONT	939	999	1,093	1,133	1,063	1,056
VIRGINIA	12,613	13,004	12,764	12,276	12,152	11,479
WASHINGTON	10,524	10,289	9,580	8,917	8,583	7,921
WEST VIRGINIA	4,106	3,893	3,751	3,630	3,551	3,323
WISCONSIN	8,770	8,937	8,878	8,723	8,816	7,837
WYOMING	987	1,125	992	998	1,028	971
AMERICAN SAMOA	63	54	82	55	59	42
GUAM	175	202	177	196	181	144
NORTHERN MARIANAS	22	58	34	62	42	30
PALAU	4	11	8	18	25	15
VIRGIN ISLANDS	94	118	131	178	122	164
BUR. OF INDIAN AFFAIRS	0	0	0	0	0	0
U.S. AND OUTLYING AREAS	520,004	528,215	510,359	488,010	470,794	438,892
50 STATES, D.C. & P.R.	519,646	527,772	509,927	487,501	470,365	438,497

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AA12

Percentage (Based on Estimated Resident Population) of Children Served Under IDEA, Part B by Age Group, During the 1998-99 School Year

All Disabilities

STATE	AGE GROUP 3-5	6-17	18-21	3-17	3-21
ALABAMA	4.20	11.90	2.15	10.38	8.55
ALASKA	5.72	11.51	1.69	10.42	8.61
ARIZONA	4.04	9.25	1.39	8.15	6.76
ARKANSAS	8.29	10.76	1.77	10.29	8.45
CALIFORNIA	3.55	9.34	1.33	8.09	6.73
COLORADO	4.63	9.09	1.43	8.23	6.82
CONNECTICUT	5.71	12.29	2.29	11.00	9.37
DELAWARE	5.59	11.64	1.86	10.43	8.56
DISTRICT OF COLUMBIA	2.15	10.82	2.48	8.88	7.46
FLORIDA	4.77	12.72	1.97	11.14	9.37
GEORGIA	4.45	10.14	1.07	8.99	7.33
HAWAII	3.12	9.26	0.95	7.98	6.41
IDAHO	6.20	9.62	1.10	8.97	7.19
ILLINOIS	5.01	11.59	1.68	10.24	8.52
INDIANA	5.53	12.35	1.86	11.01	9.06
IOWA	4.99	12.31	2.08	10.98	9.03
KANSAS	6.31	10.23	1.56	9.50	7.80
KENTUCKY	9.42	10.35	1.41	10.17	8.21
LOUISIANA	5.02	9.89	1.78	8.97	7.35
MAINE	8.77	13.84	2.36	12.99	10.76
MARYLAND	4.57	11.23	1.61	9.92	8.33
MASSACHUSETTS	6.35	14.76	2.90	13.10	11.11
MICHIGAN	4.67	10.18	1.89	9.15	7.66
MINNESOTA	5.83	10.33	1.62	9.51	7.92
MISSISSIPPI	4.91	10.29	1.60	9.25	7.55
MISSOURI	4.34	11.98	1.94	10.55	8.77
MONTANA	5.12	10.16	1.51	9.30	7.56
NEBRASKA	5.29	12.11	2.40	10.86	9.05
NEVADA	4.29	9.48	1.17	8.37	7.05
NEW HAMPSHIRE	4.78	11.38	2.48	10.20	8.77
NEW JERSEY	4.69	13.88	2.48	12.00	10.16
NEW MEXICO	6.22	13.05	2.12	11.72	9.79
NEW YORK	6.49	11.98	2.52	10.84	9.17
NORTH CAROLINA	5.25	11.17	1.26	9.98	8.20
NORTH DAKOTA	4.94	9.89	1.60	9.03	7.30
OHIO	4.08	10.16	2.14	9.01	7.58
OKLAHOMA	4.25	11.66	1.95	10.30	8.49
OREGON	4.66	10.81	1.53	9.65	7.95
PENNSYLVANIA	4.32	9.80	2.00	8.78	7.41
PUERTO RICO	2.90	6.00	1.19	5.37	4.44
RHODE ISLAND	6.45	14.87	2.54	13.24	11.11
SOUTH CAROLINA	7.09	12.95	1.50	11.83	9.55
SOUTH DAKOTA	7.06	9.16	1.41	8.78	7.15
TENNESSEE	4.67	12.41	2.27	10.88	9.02
TEXAS	3.61	11.55	2.09	9.91	8.28
UTAH	4.90	10.24	1.38	9.16	7.32
VERMONT	5.88	10.68	2.02	9.86	8.23
VIRGINIA	5.02	12.06	1.74	10.66	8.71
WASHINGTON	4.95	9.70	1.50	8.79	7.28
WEST VIRGINIA	8.33	14.87	2.26	13.67	10.92
WISCONSIN	6.60	10.25	1.82	9.59	7.96
WYOMING	8.58	11.91	2.21	11.34	9.24
AMERICAN SAMOA	1.03	2.94	0.36	2.47	2.13
GUAM	1.29	5.22	1.99	4.18	3.84
NORTHERN MARIANAS	1.35	3.48	1.13	2.93	2.53
PALAU	0.46	2.83	0.46	2.28	1.94
VIRGIN ISLANDS	2.65	5.97	1.45	5.26	4.48
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
U.S. AND OUTLYING AREAS	4.84	11.00	1.81	9.78	8.13
50 STATES AND D.C.	4.88	11.09	1.82	9.86	8.20

Please see data notes for an explanation of individual State differences.
Resident population data are provided from Population Estimates Program, Population Division and Population Studies Branch, International Program Center, U.S. Census Bureau for July 1998.
Data based on the December 1, 1998 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AA15

Percentage (Based on Estimated Resident Population) of Children Ages 3-5 Served Under IDEA, Part B by Race/Ethnicity, During the 1998-99 School Year

STATE	AMERICAN INDIAN/ALASKAN	ASIAN/PACIFIC ISLANDER	BLACK	HISPANIC	WHITE
ALABAMA	3.91	1.40	5.04	0.96	3.88
ALASKA	7.25	4.34	8.88	3.32	5.27
ARIZONA	4.34	2.30	6.43	3.62	4.19
ARKANSAS	3.91	9.25	11.32	3.80	7.66
CALIFORNIA	7.41	1.86	5.77	3.20	4.03
COLORADO	7.56	3.03	6.15	3.98	4.78
CONNECTICUT	11.37	2.14	6.88	5.66	5.68
DELAWARE	2.94	1.37	6.57	4.80	5.46
DISTRICT OF COLUMBIA	0.00	0.00	2.54	0.78	1.20
FLORIDA	0.00	0.00	0.00	0.00	0.00
GEORGIA	4.83	1.66	4.63	2.59	4.59
HAWAII	4.56	3.39	4.75	0.92	3.35
IDAHO	5.25	1.86	15.68	5.63	6.32
ILLINOIS	3.25	1.54	3.97	2.22	6.26
INDIANA	6.00	1.87	4.63	2.56	5.82
IOWA	6.10	1.85	7.57	3.08	5.06
KANSAS	8.70	2.14	7.70	5.05	6.43
KENTUCKY	3.57	3.68	11.48	4.17	9.36
LOUISIANA	5.05	1.16	5.71	1.21	4.83
MAINE	5.58	4.06	16.59	5.67	8.84
MARYLAND	5.48	2.41	4.73	2.97	4.77
MASSACHUSETTS	7.95	1.54	7.67	5.70	6.65
MICHIGAN	5.61	7.37	4.17	2.14	4.86
MINNESOTA	8.92	2.63	9.14	4.89	5.81
MISSISSIPPI	0.76	0.47	4.58	1.02	5.40
MISSOURI	2.66	1.41	4.01	2.24	4.53
MONTANA	6.83	4.27	14.43	1.66	5.02
NEBRASKA	8.27	2.49	7.56	4.57	5.24
NEVADA	9.19	2.42	6.24	3.25	4.48
NEW HAMPSHIRE	3.49	1.41	2.13	1.94	4.92
NEW JERSEY	1.77	2.69	4.62	3.56	5.21
NEW MEXICO	6.59	2.69	9.47	5.83	6.64
NEW YORK	13.92	2.19	4.98	3.54	4.43
NORTH CAROLINA	6.53	1.41	6.95	2.95	4.78
NORTH DAKOTA	4.54	3.32	6.63	3.24	5.05
OHIO	2.99	1.38	3.43	2.21	4.32
OKLAHOMA	7.59	1.86	4.39	2.16	4.07
OREGON	6.71	1.91	5.22	3.90	4.85
PENNSYLVANIA	6.07	1.70	4.59	3.55	4.39
PUERTO RICO	.	.	.	.	.
RHODE ISLAND	1.11	1.13	6.18	5.85	6.84
SOUTH CAROLINA	2.15	1.48	9.69	2.86	5.82
SOUTH DAKOTA	7.61	5.07	22.69	5.19	6.90
TENNESSEE	2.65	2.06	3.77	2.54	5.03
TEXAS	6.17	1.82	3.88	2.80	4.40
UTAH	11.28	1.91	7.65	3.47	5.03
VERMONT	12.50	2.99	13.04	0.84	5.93
VIRGINIA	10.97	2.01	5.27	4.59	5.14
WASHINGTON	9.39	2.70	8.04	5.40	4.84
WEST VIRGINIA	2.00	4.08	6.78	1.41	8.48
WISCONSIN	6.99	2.55	9.62	4.98	6.51
WYOMING	13.59	3.79	14.62	6.93	8.62
AMERICAN SAMOA	.	.	.	.	.
GUAM	.	.	.	.	.
NORTHERN MARIANAS	.	.	.	.	.
PALAU	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
50 STATES & D.C.	6.66	2.14	4.90	3.13	4.88

Please see data notes for an explanation of individual State differences.
The sum of the percentages of individual disabilities may not equal the percentage of all disabilities because of rounding.
Resident population data are provided from Population Estimates Program, Population Division U.S. Census Bureau for July 1998.
The percentage is based on the number of people within the specific race/ethnicity category in the resident population.
Data based on the December 1, 1998 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AA18

Number of Children Served Under IDEA by Disability and Age Group, During the 1989-90 Through 1998-99 School Years

Age Groups 0-2, 3-5, 3-21

	1989-90	1990-91	1991-92	1992-93	1993-94
AGE GROUP 0-2	37,014	50,924	145,313	145,179	152,287
AGE GROUP 3-5	385,587	394,766	420,403	455,449	491,685
AGE GROUP 3-21	4,638,605	4,756,517	4,920,227	5,081,023	5,271,044

Age Group 6-11

DISABILITY	1989-90	1990-91	1991-92	1992-93	1993-94
SPECIFIC LEARNING DISABILITIES	881,858	922,444	960,876	997,580	1,009,541
SPEECH OR LANGUAGE IMPAIRMENTS	863,302	875,618	882,392	888,935	900,962
MENTAL RETARDATION	216,136	214,884	218,247	209,487	220,301
EMOTIONAL DISTURBANCE	137,405	140,172	141,708	137,269	140,603
MULTIPLE DISABILITIES	43,966	50,595	50,124	52,472	55,073
HEARING IMPAIRMENTS	28,397	29,013	29,780	29,363	31,178
ORTHOPEDIC IMPAIRMENTS	25,491	26,457	27,773	29,138	31,644
OTHER HEALTH IMPAIRMENTS	25,955	28,297	29,292	33,487	43,493
VISUAL IMPAIRMENTS	10,956	11,347	11,635	11,210	11,723
AUTISM	.	.	3,046	8,914	11,158
DEAF-BLINDNESS	684	651	608	554	564
TRAUMATIC BRAIN INJURY	.	.	79	1,507	2,111
DEVELOPMENTAL DELAY	.	.	.	.	.
ALL DISABILITIES	2,234,150	2,299,478	2,355,560	2,399,916	2,458,351

Age Group 12-17

DISABILITY	1989-90	1990-91	1991-92	1992-93	1993-94
SPECIFIC LEARNING DISABILITIES	1,073,453	1,115,445	1,176,035	1,252,188	1,296,829
SPEECH OR LANGUAGE IMPAIRMENTS	106,604	108,144	112,136	104,904	112,581
MENTAL RETARDATION	271,228	264,624	266,240	258,619	269,321
EMOTIONAL DISTURBANCE	222,543	229,093	236,431	242,319	251,524
MULTIPLE DISABILITIES	32,042	35,014	36,210	38,368	42,083
HEARING IMPAIRMENTS	24,829	25,622	26,335	26,966	29,037
ORTHOPEDIC IMPAIRMENTS	18,392	18,812	19,593	19,594	21,321
OTHER HEALTH IMPAIRMENTS	22,962	24,177	25,701	29,150	35,886
VISUAL IMPAIRMENTS	9,980	10,350	10,530	10,641	11,357
AUTISM	.	.	1,749	4,893	5,832
DEAF-BLINDNESS	624	587	594	599	585
TRAUMATIC BRAIN INJURY	.	.	127	1,844	2,559
ALL DISABILITIES	1,782,657	1,831,868	1,911,681	1,990,085	2,078,915

Age Group 18-21

DISABILITY	1989-90	1990-91	1991-92	1992-93	1993-94
SPECIFIC LEARNING DISABILITIES	106,765	106,128	110,093	116,719	121,295
SPEECH OR LANGUAGE IMPAIRMENTS	4,350	4,016	4,376	4,210	4,442
MENTAL RETARDATION	76,538	71,949	68,775	64,256	64,197
EMOTIONAL DISTURBANCE	21,691	21,499	22,072	22,064	22,824
MULTIPLE DISABILITIES	11,949	12,020	12,074	12,439	12,561
HEARING IMPAIRMENTS	4,680	4,576	4,612	4,287	4,450
ORTHOPEDIC IMPAIRMENTS	4,167	4,071	4,023	3,856	3,887
OTHER HEALTH IMPAIRMENTS	3,816	3,875	3,756	3,426	3,700
VISUAL IMPAIRMENTS	1,930	1,985	1,918	1,693	1,724
AUTISM	.	.	620	1,773	2,068
DEAF-BLINDNESS	325	286	225	241	220
TRAUMATIC BRAIN INJURY	.	.	39	609	725
ALL DISABILITIES	236,211	230,405	232,583	235,573	242,092

Data from 1989-90 through 1993-94 for all age groups include children with disabilities served under Chapter 1 of ESEA (SOP). Beginning in 1994-95, all services to children and youth with disabilities were provided only through IDEA, Parts B and C. Infants and toddlers were first served under Part C in 1987-88; however, the data collection was unreliable in the early years of the program. Consequently, counts of children served under Part C are included in the totals presented only for 1991-92 forward.

Reporting on autism and traumatic brain injury was required under IDEA beginning in 1992-93 and was optional in 1991-92. States had the option of reporting children ages 3-9 under developmental delay beginning in 1997-98.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AA18

Number of Children Served Under IDEA by Disability and Age Group, During the 1989-90 Through 1998-99 School Years

Age Groups 0-2, 3-5, 3-21

	1994-95	1995-96	1996-97	1997-98	1998-99
AGE GROUP 0-2	165,351	177,286	186,527	197,625	188,926
AGE GROUP 3-5	522,709	548,593	557,070	570,315	573,637
AGE GROUP 3-21	5,430,220	5,627,544	5,787,842	5,967,300	6,114,803

Age Group 6-11

DISABILITY	1994-95	1995-96	1996-97	1997-98	1998-99
SPECIFIC LEARNING DISABILITIES	1,041,816	1,073,215	1,093,857	1,114,458	1,120,625
SPEECH OR LANGUAGE IMPAIRMENTS	905,223	910,788	928,942	939,430	947,096
MENTAL RETARDATION	229,453	235,490	239,286	240,706	240,496
EMOTIONAL DISTURBANCE	144,595	147,368	150,401	154,034	157,372
MULTIPLE DISABILITIES	43,889	46,150	48,489	51,039	49,604
HEARING IMPAIRMENTS	31,464	32,501	32,904	33,237	33,666
ORTHOPEDIC IMPAIRMENTS	33,521	34,530	35,574	35,668	36,044
OTHER HEALTH IMPAIRMENTS	56,856	71,649	84,868	97,861	110,295
VISUAL IMPAIRMENTS	11,557	11,870	11,843	12,088	12,135
AUTISM	13,716	17,666	21,669	27,342	34,797
DEAF-BLINDNESS	524	547	508	562	646
TRAUMATIC BRAIN INJURY	2,871	3,929	4,106	4,528	4,889
DEVELOPMENTAL DELAY	.	.	.	3,792	11,910
ALL DISABILITIES	2,515,485	2,585,703	2,652,447	2,715,648	2,759,575

Age Group 12-17

DISABILITY	1994-95	1995-96	1996-97	1997-98	1998-99
SPECIFIC LEARNING DISABILITIES	1,347,294	1,398,602	1,447,496	1,500,946	1,551,867
SPEECH OR LANGUAGE IMPAIRMENTS	110,859	111,833	115,352	119,503	122,661
MENTAL RETARDATION	279,214	286,953	291,672	297,657	303,320
EMOTIONAL DISTURBANCE	260,891	267,786	271,230	275,106	279,552
MULTIPLE DISABILITIES	34,231	36,365	38,776	41,902	44,112
HEARING IMPAIRMENTS	29,545	30,983	31,235	31,703	32,243
ORTHOPEDIC IMPAIRMENTS	23,069	24,591	26,528	27,482	28,887
OTHER HEALTH IMPAIRMENTS	46,054	57,714	71,133	86,677	102,593
VISUAL IMPAIRMENTS	11,445	11,864	12,072	12,033	11,991
AUTISM	6,760	8,796	10,078	12,211	15,361
DEAF-BLINDNESS	600	619	559	679	718
TRAUMATIC BRAIN INJURY	3,486	4,558	5,182	6,045	6,550
ALL DISABILITIES	2,153,448	2,240,664	2,321,313	2,411,944	2,499,855

Age Group 18-21

DISABILITY	1994-95	1995-96	1996-97	1997-98	1998-99
SPECIFIC LEARNING DISABILITIES	121,114	130,087	133,054	139,080	144,656
SPEECH OR LANGUAGE IMPAIRMENTS	4,248	4,263	4,447	4,628	4,791
MENTAL RETARDATION	61,850	63,132	62,644	64,968	67,260
EMOTIONAL DISTURBANCE	22,563	24,011	24,648	25,301	26,338
MULTIPLE DISABILITIES	11,500	12,020	12,175	13,412	14,047
HEARING IMPAIRMENTS	4,195	4,555	4,590	4,700	4,974
ORTHOPEDIC IMPAIRMENTS	3,877	4,035	4,240	4,267	4,564
OTHER HEALTH IMPAIRMENTS	4,223	4,798	5,361	6,603	7,943
VISUAL IMPAIRMENTS	1,711	1,756	1,847	1,910	2,006
AUTISM	2,188	2,614	2,628	2,964	3,418
DEAF-BLINDNESS	207	221	193	219	245
TRAUMATIC BRAIN INJURY	902	1,092	1,185	1,341	1,494
ALL DISABILITIES	238,578	252,584	257,012	269,391	281,736

Data from 1989-90 through 1993-94 for all age groups include children with disabilities served under Chapter 1 of ESEA (SOP). Beginning in 1994-95, all services to children and youth with disabilities were provided only through IDEA, Parts B and C. Infants and toddlers were first served under Part C in 1987-88; however, the data collection was unreliable in the early years of the program. Consequently, counts of children served under Part C are included in the totals presented only for 1991-92 forward.

Reporting on autism and traumatic brain injury was required under IDEA beginning in 1992-93 and was optional in 1991-92. States had the option of reporting children ages 3-9 under developmental delay beginning in 1997-98.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AA18

Number of Children Served Under IDEA by Disability and Age Group, During the 1989-90 Through 1998-99 School Years

Age Group 6-21

DISABILITY	1989-90	1990-91	1991-92	1992-93	1993-94
SPECIFIC LEARNING DISABILITIES	2,062,076	2,144,017	2,247,004	2,366,487	2,427,665
SPEECH OR LANGUAGE IMPAIRMENTS	974,256	987,778	998,904	998,049	1,017,985
MENTAL RETARDATION	563,902	551,457	553,262	532,362	553,819
EMOTIONAL DISTURBANCE	381,639	390,764	400,211	401,652	414,951
MULTIPLE DISABILITIES	87,957	97,629	98,408	103,279	109,717
HEARING IMPAIRMENTS	57,906	59,211	60,727	60,616	64,665
ORTHOPEDIC IMPAIRMENTS	48,050	49,340	51,389	52,588	56,852
OTHER HEALTH IMPAIRMENTS	52,733	56,349	58,749	66,063	83,079
VISUAL IMPAIRMENTS	22,866	23,682	24,083	23,544	24,804
AUTISM	.	.	5,415	15,580	19,058
DEAF-BLINDNESS	1,633	1,524	1,427	1,394	1,369
TRAUMATIC BRAIN INJURY	.	.	245	3,960	5,395
DEVELOPMENTAL DELAY	.	.	.	.	.
ALL DISABILITIES	4,253,018	4,361,751	4,499,824	4,625,574	4,779,359

Age Group 6-21

DISABILITY	1994-95	1995-96	1996-97	1997-98	1998-99
SPECIFIC LEARNING DISABILITIES	2,510,224	2,601,904	2,674,407	2,754,484	2,817,148
SPEECH OR LANGUAGE IMPAIRMENTS	1,020,330	1,026,884	1,048,741	1,063,561	1,074,548
MENTAL RETARDATION	570,517	585,575	593,602	603,331	611,076
EMOTIONAL DISTURBANCE	428,049	439,165	446,279	454,441	463,262
MULTIPLE DISABILITIES	89,620	94,535	99,440	107,253	107,763
HEARING IMPAIRMENTS	65,204	68,039	68,729	69,643	70,883
ORTHOPEDIC IMPAIRMENTS	60,467	63,156	66,342	67,417	69,495
OTHER HEALTH IMPAIRMENTS	107,133	134,161	161,362	191,141	220,831
VISUAL IMPAIRMENTS	24,713	25,490	25,762	26,031	26,132
AUTISM	22,664	29,076	34,375	42,517	53,576
DEAF-BLINDNESS	1,331	1,387	1,260	1,460	1,609
TRAUMATIC BRAIN INJURY	7,259	9,579	10,473	11,914	12,933
DEVELOPMENTAL DELAY	.	.	.	3,792	11,910
ALL DISABILITIES	4,907,511	5,078,951	5,230,772	5,396,985	5,541,166

Data from 1989-90 through 1993-94 for all age groups include children with disabilities served under Chapter 1 of ESEA (SOP). Beginning in 1994-95, all services to children and youth with disabilities were provided only through IDEA, Parts B and C. Infants and toddlers were first served under Part C in 1987-88; however, the data collection was unreliable in the early years of the program. Consequently, counts of children served under Part C are included in the totals presented only for 1991-92 forward.

Reporting on autism and traumatic brain injury was required under IDEA beginning in 1992-93 and was optional in 1991-92. States had the option of reporting children ages 3-9 under developmental delay beginning in 1997-98.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AB3

Number of Children Ages 3-5 Served in Different Educational Environments Under IDEA, Part B, During the 1997-98 School Year

ALL DISABILITIES

STATE	NUMBER							
	OUTSIDE REGULAR CLASS			PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR
	< 21%	21-60%	> 60%					
ALABAMA	6,524	829	431	84	52	30	0	157
ALASKA	296	154	128	0	0	0	0	0
ARIZONA	3,517	2,499	2,303	27	79	121	1	30
ARKANSAS	3,599	1,463	1,568	29	1,368	0	7	334
CALIFORNIA	30,610	3,008	21,596	1,621	370	60	21	225
COLORADO	4,616	988	1,624	198	0	6	2	57
CONNECTICUT	3,273	486	3,193	105	241	0	0	24
DELAWARE	586	405	318	83	0	0	1	2
DISTRICT OF COLUMBIA	.	.	.	.	.	.	.	.
FLORIDA	19,876	474	5,110	120	344	34	158	467
GEORGIA	7,034	3,667	3,027	291	112	12	6	125
HAWAII	.	.	.	.	.	.	.	.
IDAHO	1,646	585	179	844	106	9	1	6
ILLINOIS	13,095	995	10,298	1,801	144	86	0	41
INDIANA	5,481	820	6,540	246	0	2	0	145
IOWA	3,093	608	1,805	177	0	9	0	215
KANSAS	3,431	1,214	1,955	19	1	0	0	9
KENTUCKY	13,427	812	281	224	165	5	8	77
LOUISIANA	4,748	456	4,256	26	1	31	0	36
MAINE	1,849	110	196	194	758	0	0	569
MARYLAND	4,983	1,711	2,064	535	138	68	3	144
MASSACHUSETTS	13,602	239	1,132	31	74	.	1	37
MICHIGAN	6,566	441	4,287	3,236	.	4	0	4,343
MINNESOTA	4,965	1,337	4,290	12	1	19	3	884
MISSISSIPPI	3,219	871	1,411	291	101	13	0	119
MISSOURI	4,459	1,174	3,329	605	16	2	6	6
MONTANA	1,031	331	303	17	26	4	0	0
NEBRASKA	879	132	2,578	277	29	2	0	323
NEVADA	972	28	2,136	191	5	0	0	12
NEW HAMPSHIRE	1,249	186	648	80	20	0	0	67
NEW JERSEY	6,673	2,078	6,110	1,038	878	75	0	54
NEW MEXICO	1,644	203	2,911	140	5	2	0	38
NEW YORK	8,374	836	6,482	746	575	10	64	71
NORTH CAROLINA	12,109	661	3,016	562	327	73	13	205
NORTH DAKOTA	591	52	315	147	7	3	3	46
OHIO	5,265	1,241	7,878	3,773	0	5	0	0
OKLAHOMA	2,969	614	1,797	185	17	5	10	48
OREGON	3,265	233	1,598	312	344	1	5	171
PENNSYLVANIA	8,664	1,894	8,868	61	380	11	11	1,267
PUERTO RICO	2,622	1,075	875	162	213	0	1	0
RHODE ISLAND	1,049	409	902	23	171	0	2	3
SOUTH CAROLINA	7,814	763	2,013	121	67	3	0	150
SOUTH DAKOTA	351	574	1,233	3	2	0	5	0
TENNESSEE	7,109	1,188	1,771	86	50	3	0	31
TEXAS	17,323	1,732	11,713	260	5	3	0	209
UTAH	2,298	1,686	1,033	173	69	68	0	0
VERMONT	827	9	182	50	46	0	0	127
VIRGINIA	6,428	0	5,310	274	50	10	0	943
WASHINGTON	4,328	1,629	5,260	490	134	29	0	130
WEST VIRGINIA	3,001	432	1,516	26	0	5	0	194
WISCONSIN	5,488	1,211	6,695	261	4	8	0	40
WYOMING	258	32	6	0	0	2	1	0
AMERICAN SAMOA	73	3	3	.	.	.	.	0
GUAM	89	27	39	0	0	0	0	12
NORTHERN MARIANAS	.	.	.	.	.	.	.	.
PALAU	1	0	0	0	0	0	0	3
VIRGIN ISLANDS	.	.	.	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	276,839	44,605	164,512	20,257	7,495	833	333	12,196
50 STATES, D.C. & P.R.	276,676	44,575	164,470	20,257	7,495	833	333	12,181

Please see data notes for an explanation of individual State differences.
A crosswalk was used to report placement data for 3-5 year olds in the OSEP placement categories. See the data notes for how preschool placements were recorded and for more detail on States that used these categories.
FACIL=FACILITY; RESID=RESIDENTIAL; HOSP=HOSPITAL; ENVIR=ENVIRONMENT
Data based on the December 1, 1997 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AB3

Percentage of Children Ages 3-5 Served in Different Educational Environments Under IDEA, Part B, During the 1997-98 School Year

ALL DISABILITIES

STATE	PERCENTAGE: OUTSIDE REGULAR CLASS: < 21%	21-60%	> 60%	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR
ALABAMA	80.47	10.23	5.32	1.04	0.64	0.37	0.00	1.94
ALASKA	51.21	26.64	22.15	0.00	0.00	0.00	0.00	0.00
ARIZONA	41.01	29.14	26.85	0.31	0.92	1.41	0.01	0.35
ARKANSAS	43.01	17.48	18.76	0.35	16.35	0.00	0.08	3.99
CALIFORNIA	53.22	5.23	37.55	2.82	0.64	0.10	0.04	0.39
COLORADO	61.62	13.19	21.68	2.64	0.00	0.08	0.03	0.76
CONNECTICUT	44.70	6.64	43.61	1.43	3.29	0.00	0.00	0.33
DELAWARE	42.01	29.03	22.80	5.95	0.00	0.00	0.07	0.14
DISTRICT OF COLUMBIA	.	.	.	.	.	.	.	.
FLORIDA	74.77	1.78	19.22	0.45	1.29	0.13	0.59	1.76
GEORGIA	49.28	25.69	21.21	2.04	0.78	0.08	0.04	0.88
HAWAII	.	.	.	.	.	.	.	.
IDAHO	48.76	17.33	5.30	25.00	3.14	0.27	0.03	0.18
ILLINOIS	49.49	3.76	38.92	6.81	0.54	0.33	0.00	0.15
INDIANA	41.42	6.20	49.42	1.86	0.00	0.02	0.00	1.10
IOWA	52.36	10.29	30.56	3.00	0.00	0.15	0.00	3.64
KANSAS	51.76	18.31	29.49	0.29	0.02	0.00	0.00	0.14
KENTUCKY	89.52	5.41	1.87	1.49	1.10	0.03	0.05	0.51
LOUISIANA	49.70	4.77	44.55	0.27	0.01	0.32	0.00	0.38
MAINE	50.30	2.99	5.33	5.28	20.62	0.00	0.00	15.48
MARYLAND	51.66	17.74	21.40	5.55	1.43	0.70	0.03	1.49
MASSACHUSETTS	89.98	1.58	7.49	0.21	0.49	.	0.01	0.24
MICHIGAN	34.78	2.34	22.71	17.14	.	0.02	0.00	23.01
MINNESOTA	41.09	12.03	38.61	0.11	0.01	0.17	0.03	7.96
MISSISSIPPI	53.43	14.46	23.42	4.83	1.68	0.22	0.00	1.98
MISSOURI	46.43	12.23	34.69	6.30	0.17	0.02	0.06	0.06
MONTANA	60.22	19.33	17.70	0.99	1.52	0.23	0.00	0.00
NEBRASKA	20.83	3.13	61.09	6.56	0.69	0.05	0.00	7.65
NEVADA	29.07	0.84	63.88	5.71	0.15	0.00	0.00	0.36
NEW HAMPSHIRE	55.51	8.27	28.80	3.56	0.89	0.00	0.00	2.98
NEW JERSEY	39.47	12.29	36.14	6.14	5.19	0.44	0.00	0.32
NEW MEXICO	33.26	4.11	58.89	2.83	0.10	0.04	0.00	0.77
NEW YORK	48.81	4.87	37.78	4.35	3.35	0.06	0.37	0.41
NORTH CAROLINA	71.37	3.90	17.78	3.31	1.93	0.43	0.08	1.21
NORTH DAKOTA	50.77	4.47	27.06	12.63	0.60	0.26	0.26	3.95
OHIO	28.99	6.83	43.38	20.77	0.00	0.03	0.00	0.00
OKLAHOMA	52.60	10.88	31.83	3.28	0.30	0.09	0.18	0.85
OREGON	55.07	3.93	26.95	5.26	5.80	0.02	0.08	2.88
PENNSYLVANIA	40.95	8.95	41.92	0.29	1.80	0.05	0.05	5.99
PUERTO RICO	52.99	21.73	17.68	3.27	4.30	0.00	0.02	0.00
RHODE ISLAND	40.99	15.98	35.25	0.90	6.68	0.00	0.08	0.12
SOUTH CAROLINA	71.48	6.98	18.42	1.11	0.61	0.03	0.00	1.37
SOUTH DAKOTA	16.19	26.48	56.87	0.14	0.09	0.00	0.23	0.00
TENNESSEE	69.44	11.60	17.30	0.84	0.49	0.03	0.00	0.30
TEXAS	55.44	5.54	37.49	0.83	0.02	0.01	0.00	0.67
UTAH	43.14	31.65	19.39	3.25	1.30	1.28	0.00	0.00
VERMONT	66.64	0.73	14.67	4.03	3.71	0.00	0.00	10.23
VIRGINIA	49.39	0.00	40.80	2.11	0.38	0.08	0.00	7.25
WASHINGTON	36.07	13.58	43.83	4.08	1.12	0.24	0.00	1.08
WEST VIRGINIA	58.00	8.35	29.30	0.50	0.00	0.10	0.00	3.75
WISCONSIN	40.04	8.83	48.84	1.90	0.03	0.06	0.00	0.29
WYOMING	86.29	10.70	2.01	0.00	0.00	0.67	0.33	0.00
AMERICAN SAMOA	92.41	3.80	3.80	.	.	.	.	0.00
GUAM	53.29	16.17	23.35	0.00	0.00	0.00	0.00	7.19
NORTHERN MARIANAS	.	.	.	.	.	.	.	.
PALAU	25.00	0.00	0.00	0.00	0.00	0.00	0.00	75.00
VIRGIN ISLANDS	.	.	.	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	52.52	8.46	31.21	3.84	1.42	0.16	0.06	2.31
50 STATES, D.C. & P.R.	52.52	8.46	31.22	3.85	1.42	0.16	0.06	2.31

Please see data notes for an explanation of individual State differences.
A crosswalk was used to report placement data for 3-5 year olds in the OSEP placement categories. See the data notes for how preschool placements were recorded and for more detail on States that used these categories.
FACIL=FACILITY; RESID=RESIDENTIAL; HOSP=HOSPITAL; ENVIR=ENVIRONMENT
Data based on the December 1, 1997 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AB7

Number of Children Served in Different Educational Environments Under IDEA, Part B by Age Group During 1988-89 Through 1997-98 School Years

Age Group 3-5

	< 21%	21-60%	> 60%	Public Separate Facility	Private Separate Facility	Public Resid Facility	Private Resid Facility	Home Hosp Envir	Total
1988-89	140,364	53,706	87,595	26,106	16,698	1,080	338	6,573	332,460
1989-90	159,554	42,630	98,879	25,954	20,198	1,059	443	7,635	356,352
1990-91	163,723	47,946	99,233	30,020	18,897	969	348	7,252	368,388
1991-92	173,364	41,436	108,507	17,984	26,251	931	250	4,394	373,117
1992-93	220,018	56,599	141,566	22,199	13,222	1,541	313	7,270	462,728
1993-94	237,470	44,175	151,088	22,453	20,529	983	555	9,045	486,298
1994-95	243,226	44,657	152,000	19,539	7,070	633	245	12,474	479,844
1995-96	268,130	48,307	162,814	23,551	6,633	729	199	11,803	522,166
1996-97	262,967	46,343	166,911	20,647	8,464	700	173	10,207	516,412
1997-98	276,839	44,605	164,512	20,257	7,495	833	333	12,196	527,070

Age Group 6-11

	< 21%	21-60%	> 60%	Public Separate Facility	Private Separate Facility	Public Resid Facility	Private Resid Facility	Home Hosp Envir	Total
1988-89	898,693	762,537	449,059	45,567	22,026	5,582	2,601	7,348	2,193,413
1989-90	937,329	748,115	463,525	45,186	24,156	6,144	2,626	6,303	2,233,384
1990-91	992,884	727,000	497,003	42,739	24,773	5,402	2,545	7,370	2,299,716
1991-92	1,075,455	726,035	463,267	37,018	27,467	5,872	2,098	5,141	2,342,353
1992-93	1,164,427	617,476	477,765	37,856	25,419	7,159	2,269	7,194	2,339,565
1993-94	1,313,089	608,776	472,899	33,112	14,456	4,416	2,295	6,429	2,455,472
1994-95	1,364,545	610,920	475,664	31,959	15,000	4,057	2,161	6,226	2,510,532
1995-96	1,424,309	624,095	476,965	34,413	15,539	4,113	2,321	6,308	2,588,063
1996-97	1,475,558	635,773	478,178	32,696	15,977	3,795	2,287	6,151	2,650,413
1997-98	1,521,013	660,323	467,839	29,904	16,614	4,055	2,617	6,974	2,709,339

Age Group 12-17

	< 21%	21-60%	> 60%	Public Separate Facility	Private Separate Facility	Public Resid Facility	Private Resid Facility	Home Hosp Envir	Total
1988-89	335,057	779,691	487,524	63,144	26,071	12,918	7,210	22,532	1,734,147
1989-90	360,143	769,427	517,752	64,885	26,183	15,695	7,355	15,950	1,777,390
1990-91	400,416	783,562	526,763	59,118	27,034	14,701	7,259	14,038	1,832,891
1991-92	445,691	821,318	517,011	54,895	29,264	16,786	7,317	13,815	1,906,097
1992-93	609,919	759,618	530,137	54,342	25,825	15,179	7,655	14,517	2,017,192
1993-94	687,004	725,572	534,931	51,246	25,446	13,663	8,030	17,304	2,063,196
1994-95	745,534	731,410	548,839	50,958	27,919	14,249	8,219	18,621	2,145,749
1995-96	793,334	755,901	541,261	54,924	28,719	13,219	8,687	18,379	2,214,424
1996-97	839,216	782,239	562,917	55,888	29,759	13,391	9,455	18,708	2,311,573
1997-98	893,375	827,800	551,955	52,423	32,309	13,903	11,293	18,396	2,401,454

Beginning in 1989-90, States were instructed to report students in regular class, resource room, and separate class placements based on the percent of time they received services OUTSIDE the regular class (<21, 21-60, and >60, respectively) instead of the percent of time they received special education.

Reporting on autism and traumatic brain injury was required under IDEA beginning in 1992-93 and was optional in 1991-92.

RESID=RESIDENTIAL; HOSP=HOSPITAL; ENVIR=ENVIRONMENT

Data based on the December 1, 1997 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AC1

Total Number of Teachers Employed, Vacant Funded Positions, and Number of Teachers Retained (in Full-Time Equivalency) to Provide Special Education and Related Services for Children and Youth with Disabilities, Ages 3-5 During the 1997-98 School Year

STATE	EMPLOYED: FULLY CERTIFIED	EMPLOYED: NOT FULLY CERTIFIED	VACANT POSITIONS	TOTAL POSITIONS (EMPLOYED + VACANT)	RETAINED TEACHERS: FULLY CERTIFIED	RETAINED TEACHERS: NOT FULLY CERTIFIED
ALABAMA	727	28	17	772	662	23
ALASKA	.	.	.	.	.	.
ARIZONA	240	80	9	328	237	71
ARKANSAS	333	125	17	474	125	89
CALIFORNIA	1,812	186	9	2,007	1,678	171
COLORADO	144	44	5	193	121	28
CONNECTICUT	.	.	.	.	.	.
DELAWARE	100	6	0	106	95	3
DISTRICT OF COLUMBIA	.	.	.	.	.	.
FLORIDA	1,499	73	26	1,598	1,404	52
GEORGIA	520	9	5	534	438	5
HAWAII	128	12	0	140	.	.
IDAHO	134	4	10	148	122	4
ILLINOIS	981	43	11	1,034	816	38
INDIANA	535	20	0	555	477	14
IOWA	348	22	2	372	305	19
KANSAS	375	.	6	381	338	.
KENTUCKY	200	25	4	229	177	21
LOUISIANA	537	271	1	809	498	198
MAINE	206	0	0	206	206	0
MARYLAND	336	21	6	362	312	17
MASSACHUSETTS	579	.	5	584	553	.
MICHIGAN	588	53	3	644	382	18
MINNESOTA	701	41	2	744	620	35
MISSISSIPPI	301	11	5	318	281	7
MISSOURI	483	146	0	629	401	0
MONTANA	83	3	1	87	76	2
NEBRASKA	84	2	2	87	80	2
NEVADA	196	16	1	212	175	13
NEW HAMPSHIRE	97	11	0	108	90	7
NEW JERSEY	923	0	4	927	825	0
NEW MEXICO	193	29	0	223	191	24
NEW YORK	1,836	932	85	2,853	1,540	574
NORTH CAROLINA	673	93	20	786	594	65
NORTH DAKOTA	70	6	1	76	63	3
OHIO	1,246	0	86	1,332	805	0
OKLAHOMA	238	7	3	249	223	4
OREGON	138	7	3	148	116	7
PENNSYLVANIA	1,237	0	1	1,237	1,087	0
PUERTO RICO	90	0	0	90	0	0
RHODE ISLAND	129	4	0	132	118	3
SOUTH CAROLINA	274	15	7	295	222	6
SOUTH DAKOTA	94	2	0	97	87	1
TENNESSEE	329	3	2	334	329	3
TEXAS	283	32	.	315	236	25
UTAH	496	34	2	532	451	26
VERMONT	92	1	0	93	79	0
VIRGINIA	1,222	211	10	1,442	1,137	150
WASHINGTON	466	7	3	476	442	3
WEST VIRGINIA	184	19	1	204	170	13
WISCONSIN	675	14	5	694	594	4
WYOMING	53	13	.	66	.	.
AMERICAN SAMOA	3	8	0	11	3	4
GUAM	145	13	15	173	133	1
NORTHERN MARIANAS	2	0	.	2	.	.
PALAU	1	1	0	2	1	1
VIRGIN ISLANDS	.	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	23,359	2,701	391	26,450	20,115	1,751
50 STATES, D.C. & P.R.	23,208	2,679	376	26,262	19,978	1,745

Please see data notes for an explanation of individual State differences.
The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the individual States and Outlying Areas because of rounding.
Data based on the December 1, 1997 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AF1

Estimated Resident Population for Children Ages 3-21

STATE	NUMBER			CHANGE IN NUMBER		PERCENTAGE CHANGE IN NUMBER	
	1988-89	1997-98	1998-99	1998-99 LESS 1988-89	1998-99 LESS 1997-98	1998-99 LESS 1988-89	1998-99 LESS 1997-98
ALABAMA	1,193,000	1,153,423	1,167,765	-25,235	14,342	-2.12	1.24
ALASKA	168,000	200,085	205,601	37,601	5,516	22.38	2.76
ARIZONA	977,000	1,303,563	1,309,917	332,917	6,354	34.08	0.49
ARKANSAS	690,000	703,616	699,195	9,195	-4,421	1.33	-0.63
CALIFORNIA	7,667,000	9,142,375	9,260,614	1,593,614	118,239	20.79	1.29
COLORADO	908,000	1,068,542	1,102,056	194,056	33,514	21.37	3.14
CONNECTICUT	814,000	814,280	819,287	5,287	5,007	0.65	0.61
DELAWARE	178,000	186,270	189,738	11,738	3,468	6.59	1.86
DISTRICT OF COLUMBIA	143,000	111,021	109,400	-33,600	-1,621	-23.50	-1.46
FLORIDA	2,931,000	3,592,228	3,683,137	752,137	90,909	25.66	2.53
GEORGIA	1,883,000	2,080,868	2,126,029	243,029	45,161	12.91	2.17
HAWAII	304,000	319,675	320,701	16,701	1,026	5.49	0.32
IDAHO	317,000	380,341	383,464	66,464	3,123	20.97	0.82
ILLINOIS	3,173,000	3,282,719	3,331,502	158,502	48,783	5.00	1.49
INDIANA	1,573,000	1,593,093	1,617,244	44,244	24,151	2.81	1.52
IOWA	769,000	782,537	786,126	17,126	3,589	2.23	0.46
KANSAS	685,000	734,235	749,493	64,493	15,258	9.42	2.08
KENTUCKY	1,066,000	1,045,685	1,071,475	5,475	25,790	0.51	2.47
LOUISIANA	1,356,000	1,289,186	1,296,134	-59,866	6,948	-4.41	0.54
MAINE	328,000	322,300	318,600	-9,400	-3,700	-2.87	-1.15
MARYLAND	1,221,000	1,312,503	1,341,405	120,405	28,902	9.86	2.20
MASSACHUSETTS	1,454,000	1,502,271	1,521,216	67,216	18,945	4.62	1.26
MICHIGAN	2,627,000	2,666,067	2,719,948	92,948	53,881	3.54	2.02
MINNESOTA	1,179,000	1,322,446	1,340,862	161,862	18,416	13.73	1.39
MISSISSIPPI	831,000	812,081	818,793	-12,207	6,712	-1.47	0.83
MISSOURI	1,389,000	1,487,741	1,499,753	110,753	12,012	7.97	0.81
MONTANA	230,000	251,456	248,620	18,620	-2,836	8.10	-1.13
NEBRASKA	447,000	475,275	479,349	32,349	4,074	7.24	0.86
NEVADA	272,000	445,655	472,906	200,906	27,251	73.86	6.11
NEW HAMPSHIRE	293,000	308,512	313,510	20,510	4,998	7.00	1.62
NEW JERSEY	1,961,000	2,049,248	2,067,125	106,125	17,877	5.41	0.87
NEW MEXICO	461,000	525,405	532,499	71,499	7,094	15.51	1.35
NEW YORK	4,645,000	4,701,677	4,710,492	65,492	8,815	1.41	0.19
NORTH CAROLINA	1,783,000	1,967,408	2,017,131	234,131	49,723	13.13	2.53
NORTH DAKOTA	192,000	181,816	180,570	-11,430	-1,246	-5.95	-0.69
OHIO	3,010,000	3,013,862	3,037,470	27,470	23,608	0.91	0.78
OKLAHOMA	933,000	941,823	945,564	12,564	3,741	1.35	0.40
OREGON	727,000	861,485	879,730	152,730	18,245	21.01	2.12
PENNSYLVANIA	3,073,000	3,038,836	3,057,047	-15,953	18,211	-0.52	0.60
PUERTO RICO	.	1,231,729	1,221,051	.	-10,678	.	-0.87
RHODE ISLAND	252,000	245,590	251,130	-870	5,540	-0.35	2.26
SOUTH CAROLINA	1,020,000	1,026,323	1,036,799	16,799	10,476	1.65	1.02
SOUTH DAKOTA	205,000	215,248	219,549	14,549	4,301	7.10	2.00
TENNESSEE	1,351,000	1,406,801	1,421,544	70,544	14,743	5.22	1.05
TEXAS	5,122,000	5,782,760	5,879,084	757,084	96,324	14.78	1.67
UTAH	635,000	739,491	755,133	120,133	15,642	18.92	2.12
VERMONT	154,000	156,315	154,339	339	-1,976	0.22	-1.26
VIRGINIA	1,599,000	1,748,871	1,765,044	166,044	16,173	10.38	0.92
WASHINGTON	1,253,000	1,537,054	1,568,524	315,524	31,470	25.18	2.05
WEST VIRGINIA	526,000	460,967	457,283	-68,717	-3,684	-13.06	-0.80
WISCONSIN	1,354,000	1,442,818	1,460,937	106,937	18,119	7.90	1.26
WYOMING	147,000	145,521	144,282	-2,718	-1,239	-1.85	-0.85
AMERICAN SAMOA	.	26,551	27,434	.	883	.	3.33
GUAM	.	52,093	54,004	.	1,911	.	3.67
NORTHERN MARIANAS	.	17,979	18,745	.	766	.	4.26
PALAU	.	5,714	5,770	.	56	.	0.98
VIRGIN ISLANDS	.	39,477	39,542	.	65	.	0.16
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	67,469,000	74,252,911	75,211,662	7,742,662	958,751	11.48	1.29
50 STATES AND D.C.	67,469,000	72,879,368	73,845,116	6,376,116	965,748	9.45	1.33

Population counts are July estimates from the U.S. Bureau of the Census.

Data as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AF2

Estimated Resident Population for Children Birth Through Age 2

STATE	NUMBER			CHANGE IN NUMBER		PERCENTAGE CHANGE IN NUMBER	
	1988-89	1997-98	1998-99	1998-99 LESS 1988-89	1998-99 LESS 1997-98	1998-99 LESS 1988-89	1998-99 LESS 1997-98
ALABAMA	172,281	174,259	176,418	4,137	2,159	2.40	1.24
ALASKA	35,020	29,080	29,254	-5,766	174	-16.46	0.60
ARIZONA	176,700	225,209	221,779	45,079	-3,430	25.51	-1.52
ARKANSAS	100,135	106,364	105,303	5,168	-1,061	5.16	-1.00
CALIFORNIA	1,412,146	1,566,637	1,510,466	98,320	-56,171	6.96	-3.59
COLORADO	157,710	163,943	167,378	9,668	3,435	6.13	2.10
CONNECTICUT	136,441	128,413	125,129	-11,312	-3,284	-8.29	-2.56
DELAWARE	28,824	29,305	29,478	654	173	2.27	0.59
DISTRICT OF COLUMBIA	24,221	19,293	17,842	-6,379	-1,451	-26.34	-7.52
FLORIDA	501,115	561,182	566,976	65,861	5,794	13.14	1.03
GEORGIA	294,448	334,245	342,836	48,388	8,591	16.43	2.57
HAWAII	51,405	52,126	49,331	-2,074	-2,795	-4.03	-5.36
IDAHO	48,076	54,820	54,824	6,748	4	14.04	0.01
ILLINOIS	511,792	535,100	525,754	13,962	-9,346	2.73	-1.75
INDIANA	235,673	242,721	244,998	9,325	2,277	3.96	0.94
IOWA	114,279	109,240	108,278	-6,001	-962	-5.25	-0.88
KANSAS	114,381	107,053	108,931	-5,450	1,878	-4.76	1.75
KENTUCKY	150,325	152,981	156,625	6,300	3,644	4.19	2.38
LOUISIANA	213,564	186,085	187,711	-25,853	1,626	-12.11	0.87
MAINE	50,574	40,458	39,644	-10,930	-814	-21.61	-2.01
MARYLAND	211,500	205,540	203,711	-7,789	-1,829	-3.68	-0.89
MASSACHUSETTS	246,612	235,722	233,102	-13,510	-2,620	-5.48	-1.11
MICHIGAN	416,285	385,371	388,524	-27,761	3,153	-6.67	0.82
MINNESOTA	198,696	187,175	189,163	-9,533	1,988	-4.80	1.06
MISSISSIPPI	119,259	119,726	120,448	1,189	722	1.00	0.60
MISSOURI	221,767	217,365	216,559	-5,208	-806	-2.35	-0.37
MONTANA	36,893	31,957	31,304	-5,589	-653	-15.15	-2.04
NEBRASKA	72,207	68,425	68,528	-3,679	103	-5.10	0.15
NEVADA	50,674	78,279	81,257	30,583	2,978	60.35	3.80
NEW HAMPSHIRE	49,355	43,136	43,008	-6,347	-128	-12.86	-0.30
NEW JERSEY	325,199	327,186	322,197	-3,002	-4,989	-0.92	-1.52
NEW MEXICO	78,515	79,296	78,873	358	-423	0.46	-0.53
NEW YORK	761,560	780,741	737,787	-23,773	-42,954	-3.12	-5.50
NORTH CAROLINA	270,799	308,426	315,247	44,448	6,821	16.41	2.21
NORTH DAKOTA	30,807	24,239	24,009	-6,798	-230	-22.07	-0.95
OHIO	470,799	444,315	440,737	-30,062	-3,578	-6.39	-0.81
OKLAHOMA	142,315	134,579	138,357	-3,958	3,778	-2.78	2.81
OREGON	116,302	127,662	129,648	13,346	1,986	11.48	1.56
PENNSYLVANIA	477,549	432,098	420,959	-56,590	-11,139	-11.85	-2.58
PUERTO RICO	.	190,281	190,376	.	95	.	0.05
RHODE ISLAND	40,679	36,449	36,694	-3,985	245	-9.80	0.67
SOUTH CAROLINA	153,282	149,677	151,500	-1,782	1,823	-1.16	1.22
SOUTH DAKOTA	34,023	29,637	29,897	-4,126	260	-12.13	0.88
TENNESSEE	197,925	215,511	216,285	18,360	774	9.28	0.36
TEXAS	858,244	967,997	974,795	116,551	6,798	13.58	0.70
UTAH	105,061	120,459	125,154	20,093	4,695	19.13	3.90
VERMONT	24,373	19,976	19,070	-5,303	-906	-21.76	-4.54
VIRGINIA	262,692	268,654	266,199	3,507	-2,455	1.34	-0.91
WASHINGTON	212,409	229,234	230,152	17,743	918	8.35	0.40
WEST VIRGINIA	65,991	60,816	57,172	-8,819	-3,644	-13.36	-5.99
WISCONSIN	215,779	197,539	196,296	-19,483	-1,243	-9.03	-0.63
WYOMING	22,865	18,327	18,346	-4,519	19	-19.76	0.10
AMERICAN SAMOA	.	5,151	5,052	.	-99	.	-1.92
GUAM	.	11,924	11,464	.	-460	.	-3.86
NORTHERN MARIANAS	.	3,828	3,871	.	43	.	1.12
PALAU	.	1,104	1,096	.	-8	.	-0.72
VIRGIN ISLANDS	.	6,143	5,789	.	-354	.	-5.76
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	11,019,526	11,582,459	11,491,581	472,055	-90,878	4.28	-0.78
50 STATES AND D.C.	11,019,526	11,364,028	11,273,933	254,407	-90,095	2.31	-0.79

Population counts are July estimates from the U.S. Bureau of the Census.

Data as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AF3

Estimated Resident Population for Children Ages 3-5

STATE	NUMBER			CHANGE IN NUMBER		PERCENTAGE CHANGE IN NUMBER	
	1988-89	1997-98	1998-99	1998-99 LESS 1988-89	1998-99 LESS 1997-98	1998-99 LESS 1988-89	1998-99 LESS 1997-98
ALABAMA	179,000	179,373	178,728	-272	-645	-0.15	-0.36
ALASKA	35,000	31,060	30,682	-4,318	-378	-12.34	-1.22
ARIZONA	172,000	223,494	219,952	47,952	-3,542	27.88	-1.58
ARKANSAS	105,000	106,698	104,654	-346	-2,044	-0.33	-1.92
CALIFORNIA	1,375,000	1,664,193	1,599,138	224,138	-65,055	16.30	-3.91
COLORADO	160,000	166,148	168,945	8,945	2,797	5.59	1.68
CONNECTICUT	128,000	134,186	130,446	2,446	-3,740	1.91	-2.79
DELAWARE	28,000	30,199	29,782	1,782	-417	6.36	-1.38
DISTRICT OF COLUMBIA	27,000	21,101	19,025	-7,975	-2,076	-29.54	-9.84
FLORIDA	498,000	590,946	591,306	93,306	360	18.74	0.06
GEORGIA	294,000	338,060	339,749	45,749	1,689	15.56	0.50
HAWAII	53,000	54,867	52,698	-302	-2,169	-0.57	-3.95
IDAHO	51,000	55,711	55,905	4,905	194	9.62	0.35
ILLINOIS	508,000	555,951	548,958	40,958	-6,993	8.06	-1.26
INDIANA	234,000	248,473	249,013	15,013	540	6.42	0.22
IOWA	118,000	113,128	111,697	-6,303	-1,431	-5.34	-1.26
KANSAS	115,000	109,215	109,908	-5,092	693	-4.43	0.63
KENTUCKY	155,000	156,999	160,955	5,955	3,956	3.84	2.52
LOUISIANA	232,000	193,712	189,229	-42,771	-4,483	-18.44	-2.31
MAINE	50,000	44,744	42,096	-7,904	-2,648	-15.81	-5.92
MARYLAND	200,000	215,657	212,774	12,774	-2,883	6.39	-1.34
MASSACHUSETTS	228,000	248,384	242,128	14,128	-6,256	6.20	-2.52
MICHIGAN	394,000	407,598	406,565	12,565	-1,033	3.19	-0.25
MINNESOTA	194,000	195,287	194,307	307	-980	0.16	-0.50
MISSISSIPPI	128,000	124,334	123,105	-4,895	-1,229	-3.82	-0.99
MISSOURI	222,000	227,509	223,355	1,355	-4,154	0.61	-1.83
MONTANA	39,000	34,217	32,964	-6,036	-1,253	-15.48	-3.66
NEBRASKA	73,000	69,249	69,171	-3,829	-78	-5.25	-0.11
NEVADA	48,000	77,295	82,258	34,258	4,963	71.37	6.42
NEW HAMPSHIRE	46,000	46,739	45,820	-180	-919	-0.39	-1.97
NEW JERSEY	302,000	348,931	340,794	38,794	-8,137	12.85	-2.33
NEW MEXICO	81,000	82,907	82,584	1,584	-323	1.96	-0.39
NEW YORK	736,000	808,673	779,578	43,578	-29,095	5.92	-3.60
NORTH CAROLINA	264,000	319,637	321,709	57,709	2,072	21.86	0.65
NORTH DAKOTA	33,000	24,782	24,225	-8,775	-557	-26.59	-2.25
OHIO	462,000	462,933	455,314	-6,686	-7,619	-1.45	-1.65
OKLAHOMA	160,000	139,602	136,645	-23,355	-2,957	-14.60	-2.12
OREGON	114,000	128,687	131,509	17,509	2,822	15.36	2.19
PENNSYLVANIA	470,000	466,700	455,266	-14,734	-11,434	-3.13	-2.45
PUERTO RICO	.	192,450	191,692	.	-758	.	-0.39
RHODE ISLAND	39,000	38,801	38,908	-92	107	-0.24	0.28
SOUTH CAROLINA	156,000	159,403	154,350	-1,650	-5,053	-1.06	-3.17
SOUTH DAKOTA	35,000	30,203	30,642	-4,358	439	-12.45	1.45
TENNESSEE	200,000	221,975	220,410	20,410	-1,565	10.21	-0.71
TEXAS	906,000	964,099	964,155	58,155	56	6.42	0.01
UTAH	111,000	112,682	116,582	5,582	3,900	5.03	3.46
VERMONT	24,000	22,234	20,861	-3,139	-1,373	-13.08	-6.18
VIRGINIA	250,000	278,590	273,187	23,187	-5,403	9.27	-1.94
WASHINGTON	208,000	238,348	238,187	30,187	-161	14.51	-0.07
WEST VIRGINIA	71,000	64,995	63,670	-7,330	-1,325	-10.32	-2.04
WISCONSIN	216,000	209,183	207,689	-8,311	-1,494	-3.85	-0.71
WYOMING	26,000	19,334	18,825	-7,175	-509	-27.60	-2.63
AMERICAN SAMOA	.	5,729	5,641	.	-88	.	-1.54
GUAM	.	11,736	12,122	.	386	.	3.29
NORTHERN MARIANAS	.	3,769	3,780	.	11	.	0.29
PALAU	.	1,065	1,087	.	22	.	2.07
VIRGIN ISLANDS	.	7,013	6,786	.	-227	.	-3.24
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	10,953,000	12,028,988	11,861,511	908,511	-167,477	8.29	-1.39
50 STATES AND D.C.	10,953,000	11,807,226	11,640,403	687,403	-166,823	6.28	-1.41

Population counts are July estimates form the U.S. Bureau of the Census.

Data as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AF6

Estimated Resident Population (Number) for Children Ages Birth Through 2 by Race/Ethnicity for the 1998-99 School Year

STATE	AMERICAN INDIAN	ASIAN/ PACIFIC	BLACK	HISPANIC	WHITE
ALABAMA	341	1,634	54,203	3,145	117,095
ALASKA	7,150	1,344	1,165	1,757	17,838
ARIZONA	12,738	4,306	5,699	82,616	116,420
ARKANSAS	727	1,107	21,284	3,500	78,685
CALIFORNIA	5,018	159,856	84,432	693,017	568,143
COLORADO	1,044	5,003	6,172	41,250	113,909
CONNECTICUT	187	4,015	12,148	19,092	89,687
DELAWARE	32	687	6,555	1,853	20,351
DISTRICT OF COLUMBIA	12	399	13,588	1,678	2,165
FLORIDA	1,507	12,219	113,045	103,993	336,212
GEORGIA	529	7,362	109,044	16,191	209,710
HAWAII	244	31,887	1,045	6,207	9,948
IDAHO	630	759	180	7,158	46,097
ILLINOIS	452	19,226	92,365	91,168	322,543
INDIANA	362	3,091	23,546	9,843	208,156
IOWA	309	2,312	2,691	4,118	98,848
KANSAS	687	2,603	6,996	10,710	87,935
KENTUCKY	159	1,429	12,906	2,416	139,715
LOUISIANA	727	3,130	72,693	5,931	105,230
MAINE	229	523	241	574	38,077
MARYLAND	451	9,404	64,919	10,771	118,166
MASSACHUSETTS	537	15,858	20,912	28,578	167,217
MICHIGAN	2,064	8,307	63,587	19,656	294,910
MINNESOTA	2,889	8,940	8,500	7,099	161,735
MISSISSIPPI	571	1,150	53,166	1,492	64,069
MISSOURI	579	3,613	29,821	5,841	176,705
MONTANA	3,444	322	98	1,186	26,254
NEBRASKA	906	1,476	3,252	5,107	57,787
NEVADA	945	4,212	5,304	20,588	50,208
NEW HAMPSHIRE	61	645	266	1,087	40,949
NEW JERSEY	474	23,704	49,067	56,115	192,837
NEW MEXICO	8,414	1,043	1,007	42,375	26,034
NEW YORK	1,456	47,919	111,529	168,118	408,765
NORTH CAROLINA	4,780	6,533	75,424	13,645	214,865
NORTH DAKOTA	2,184	368	281	599	20,577
OHIO	811	7,722	66,200	12,499	353,505
OKLAHOMA	15,166	2,586	13,783	10,371	96,451
OREGON	1,515	5,602	2,317	15,221	104,993
PENNSYLVANIA	452	10,301	50,684	21,308	338,214
PUERTO RICO	.	.	.	.	.
RHODE ISLAND	318	1,236	1,816	4,675	28,649
SOUTH CAROLINA	328	1,866	50,593	3,469	95,244
SOUTH DAKOTA	4,665	300	235	783	23,974
TENNESSEE	383	3,206	44,584	4,240	163,872
TEXAS	1,599	26,451	98,821	426,537	421,387
UTAH	1,559	4,066	737	12,097	106,695
VERMONT	33	204	66	205	18,562
VIRGINIA	416	12,752	56,779	15,874	180,378
WASHINGTON	4,123	16,465	7,730	27,599	174,235
WEST VIRGINIA	45	519	2,371	655	53,582
WISCONSIN	2,333	6,159	16,065	9,956	161,783
WYOMING	576	196	112	1,985	15,477
AMERICAN SAMOA	.	.	.	.	.
GUAM	.	.	.	.	.
NORTHERN MARIANAS	.	.	.	.	.
PALAU	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
50 STATES & D.C.	97,161	496,017	1,540,024	2,055,888	7,084,843

Population counts are July estimates from the U.S. Bureau of the Census.

Data as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AF6

Estimated Resident Population (Percent) for Children Ages Birth Through 2 by Race/Ethnicity for the 1998-99 School Year

STATE	AMERICAN INDIAN	ASIAN/ PACIFIC	BLACK	HISPANIC	WHITE
ALABAMA	0.19	0.93	30.72	1.78	66.37
ALASKA	24.44	4.59	3.98	6.01	60.98
ARIZONA	5.74	1.94	2.57	37.25	52.49
ARKANSAS	0.69	1.05	20.21	3.32	74.72
CALIFORNIA	0.33	10.58	5.59	45.88	37.61
COLORADO	0.62	2.99	3.69	24.64	68.05
CONNECTICUT	0.15	3.21	9.71	15.26	71.68
DELAWARE	0.11	2.33	22.24	6.29	69.04
DISTRICT OF COLUMBIA	0.07	2.24	76.16	9.40	12.13
FLORIDA	0.27	2.16	19.94	18.34	59.30
GEORGIA	0.15	2.15	31.81	4.72	61.17
HAWAII	0.49	64.64	2.12	12.58	20.17
IDAHO	1.15	1.38	0.33	13.06	84.08
ILLINOIS	0.09	3.66	17.57	17.34	61.35
INDIANA	0.15	1.26	9.61	4.02	84.96
IOWA	0.29	2.14	2.49	3.80	91.29
KANSAS	0.63	2.39	6.42	9.83	80.73
KENTUCKY	0.10	0.91	8.24	1.54	89.20
LOUISIANA	0.39	1.67	38.73	3.16	56.06
MAINE	0.58	1.32	0.61	1.45	96.05
MARYLAND	0.22	4.62	31.87	5.29	58.01
MASSACHUSETTS	0.23	6.80	8.97	12.26	71.74
MICHIGAN	0.53	2.14	16.37	5.06	75.91
MINNESOTA	1.53	4.73	4.49	3.75	85.50
MISSISSIPPI	0.47	0.95	44.14	1.24	53.19
MISSOURI	0.27	1.67	13.77	2.70	81.60
MONTANA	11.00	1.03	0.31	3.79	83.87
NEBRASKA	1.32	2.15	4.75	7.45	84.33
NEVADA	1.16	5.18	6.53	25.34	61.79
NEW HAMPSHIRE	0.14	1.50	0.62	2.53	95.21
NEW JERSEY	0.15	7.36	15.23	17.42	59.85
NEW MEXICO	10.67	1.32	1.28	53.73	33.01
NEW YORK	0.20	6.49	15.12	22.79	55.40
NORTH CAROLINA	1.52	2.07	23.93	4.33	68.16
NORTH DAKOTA	9.10	1.53	1.17	2.49	85.71
OHIO	0.18	1.75	15.02	2.84	80.21
OKLAHOMA	10.96	1.87	9.96	7.50	69.71
OREGON	1.17	4.32	1.79	11.74	80.98
PENNSYLVANIA	0.11	2.45	12.04	5.06	80.34
PUERTO RICO	.	.	.	.	.
RHODE ISLAND	0.87	3.37	4.95	12.74	78.08
SOUTH CAROLINA	0.22	1.23	33.39	2.29	62.87
SOUTH DAKOTA	15.60	1.00	0.79	2.42	80.19
TENNESSEE	0.18	1.48	20.61	1.96	75.77
TEXAS	0.16	2.71	10.14	43.76	43.23
UTAH	1.25	3.25	0.59	9.67	85.25
VERMONT	0.17	1.07	0.35	1.07	97.34
VIRGINIA	0.16	4.79	21.33	5.96	67.76
WASHINGTON	1.79	7.15	3.36	11.99	75.70
WEST VIRGINIA	0.08	0.91	4.15	1.15	93.72
WISCONSIN	1.19	3.14	8.18	5.07	82.42
WYOMING	3.14	1.07	0.61	10.82	84.36
AMERICAN SAMOA	.	.	.	.	.
GUAM	.	.	.	.	.
NORTHERN MARIANAS	.	.	.	.	.
PALAU	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
50 STATES & D.C.	0.86	4.40	13.66	18.24	62.84

Population counts are July estimates from the U.S. Bureau of the Census.

Data as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AF7

Estimated Resident Population (Number) for Children Ages 3-5 by Race/Ethnicity for the 1998-99 School Year

STATE	AMERICAN INDIAN	ASIAN/ PACIFIC	BLACK	HISPANIC	WHITE
ALABAMA	358	1,501	57,895	2,908	116,066
ALASKA	7,156	1,476	1,138	1,625	19,287
ARIZONA	14,848	4,388	6,561	74,640	119,515
ARKANSAS	537	897	22,012	3,602	77,606
CALIFORNIA	5,948	169,976	97,800	701,676	623,738
COLORADO	1,058	4,628	7,225	38,241	117,793
CONNECTICUT	299	4,024	13,392	17,776	94,955
DELAWARE	68	657	6,955	1,729	20,373
DISTRICT OF COLUMBIA	18	545	14,505	1,797	2,160
FLORIDA	1,524	11,984	122,564	104,771	350,463
GEORGIA	476	7,645	115,441	14,445	201,742
HAWAII	263	34,209	1,179	6,315	10,732
IDAHO	648	699	185	6,645	47,728
ILLINOIS	493	18,477	107,545	86,722	335,721
INDIANA	350	2,777	25,413	9,403	211,070
IOWA	410	2,220	2,801	3,963	102,303
KANSAS	793	2,520	7,638	9,934	89,023
KENTUCKY	168	1,360	13,694	2,087	143,646
LOUISIANA	772	2,857	76,334	5,847	103,419
MAINE	233	468	217	529	40,649
MARYLAND	566	9,512	67,644	10,660	124,392
MASSACHUSETTS	390	12,958	20,050	27,258	181,472
MICHIGAN	2,300	7,607	72,816	18,167	305,675
MINNESOTA	3,239	8,780	8,423	6,754	167,111
MISSISSIPPI	528	1,056	56,100	1,371	64,050
MISSOURI	640	3,200	33,892	5,573	180,050
MONTANA	3,425	328	97	1,024	28,090
NEBRASKA	943	1,403	3,386	5,122	58,317
NEVADA	1,154	3,794	6,575	19,965	50,770
NEW HAMPSHIRE	86	640	235	1,132	43,727
NEW JERSEY	849	18,991	53,650	56,096	211,208
NEW MEXICO	10,076	1,002	1,172	41,856	28,478
NEW YORK	2,097	44,069	122,294	165,836	445,282
NORTH CAROLINA	5,254	5,823	84,241	11,630	214,761
NORTH DAKOTA	2,225	392	181	556	20,871
OHIO	803	6,972	71,084	11,855	364,600
OKLAHOMA	12,117	2,210	12,605	9,291	100,422
OREGON	1,595	5,278	2,528	14,596	107,512
PENNSYLVANIA	511	10,106	59,445	21,527	363,677
PUERTO RICO	.	.	.	.	.
RHODE ISLAND	270	1,329	2,088	4,533	30,688
SOUTH CAROLINA	325	1,690	55,113	3,075	94,147
SOUTH DAKOTA	4,666	355	216	694	24,711
TENNESSEE	378	2,666	47,958	3,972	165,436
TEXAS	1,702	25,538	111,141	397,907	427,867
UTAH	1,649	3,402	719	10,626	100,186
VERMONT	32	268	92	238	20,231
VIRGINIA	401	11,239	62,064	15,087	184,396
WASHINGTON	4,345	16,534	8,555	26,389	182,364
WEST VIRGINIA	50	368	2,374	569	60,309
WISCONSIN	2,446	6,072	17,963	9,525	171,683
WYOMING	537	211	130	1,832	16,115
AMERICAN SAMOA	.	.	.	.	.
GUAM	.	.	.	.	.
NORTHERN MARIANAS	.	.	.	.	.
PALAU	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
50 STATES & D.C.	102,019	487,101	1,685,325	1,999,371	7,366,587

Population counts are July estimates from the U.S. Bureau of the Census.

Data as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AF7

Estimated Resident Population (Percent) for Children Ages 3-5 by Race/Ethnicity for the 1998-99 School Year

STATE	AMERICAN INDIAN	ASIAN/ PACIFIC	BLACK	HISPANIC	WHITE
ALABAMA	0.20	0.84	32.39	1.63	64.94
ALASKA	23.32	4.81	3.71	5.30	62.86
ARIZONA	6.75	1.99	2.98	33.93	54.34
ARKANSAS	0.51	0.86	21.03	3.44	74.15
CALIFORNIA	0.37	10.63	6.12	43.88	39.00
COLORADO	0.63	2.74	4.28	22.64	69.72
CONNECTICUT	0.23	3.08	10.27	13.63	72.79
DELAWARE	0.23	2.21	23.35	5.81	68.41
DISTRICT OF COLUMBIA	0.09	2.86	76.24	9.45	11.35
FLORIDA	0.26	2.03	20.73	17.72	59.27
GEORGIA	0.14	2.25	33.98	4.25	59.38
HAWAII	0.50	64.92	2.24	11.98	20.37
IDAHO	1.16	1.25	0.33	11.89	85.37
ILLINOIS	0.09	3.37	19.59	15.80	61.16
INDIANA	0.14	1.12	10.21	3.78	84.76
IOWA	0.37	1.99	2.51	3.55	91.59
KANSAS	0.72	2.29	6.95	9.04	81.00
KENTUCKY	0.10	0.84	8.51	1.30	89.25
LOUISIANA	0.41	1.51	40.34	3.09	54.65
MAINE	0.55	1.11	0.52	1.26	96.56
MARYLAND	0.27	4.47	31.79	5.01	58.46
MASSACHUSETTS	0.16	5.35	8.28	11.26	74.95
MICHIGAN	0.57	1.87	17.91	4.47	75.18
MINNESOTA	1.67	4.52	4.33	3.48	86.00
MISSISSIPPI	0.43	0.86	45.57	1.11	52.03
MISSOURI	0.29	1.43	15.17	2.50	80.61
MONTANA	10.39	1.00	0.29	3.11	85.21
NEBRASKA	1.36	2.03	4.90	7.40	84.31
NEVADA	1.40	4.61	7.99	24.27	61.72
NEW HAMPSHIRE	0.19	1.40	0.51	2.47	95.43
NEW JERSEY	0.25	5.57	15.74	16.46	61.98
NEW MEXICO	12.20	1.21	1.42	50.68	34.48
NEW YORK	0.27	5.65	15.69	21.27	57.12
NORTH CAROLINA	1.63	1.81	26.19	3.62	66.76
NORTH DAKOTA	9.18	1.62	0.75	2.30	86.15
OHIO	0.18	1.53	15.61	2.60	80.08
OKLAHOMA	8.87	1.62	9.22	6.80	73.49
OREGON	1.21	4.01	1.92	11.10	81.75
PENNSYLVANIA	0.11	2.22	13.06	4.73	79.88
PUERTO RICO	.	.	.	.	.
RHODE ISLAND	0.69	3.42	5.37	11.65	78.87
SOUTH CAROLINA	0.21	1.09	35.71	1.99	61.00
SOUTH DAKOTA	15.23	1.16	0.70	2.26	80.64
TENNESSEE	0.17	1.21	21.76	1.80	75.06
TEXAS	0.18	2.65	11.53	41.27	44.38
UTAH	1.41	2.92	0.62	9.11	85.94
VERMONT	0.15	1.28	0.44	1.14	96.98
VIRGINIA	0.15	4.11	22.72	5.52	67.50
WASHINGTON	1.82	6.94	3.59	11.08	76.56
WEST VIRGINIA	0.08	0.58	3.73	0.89	94.72
WISCONSIN	1.18	2.92	8.65	4.59	82.66
WYOMING	2.85	1.12	0.69	9.73	85.60
AMERICAN SAMOA	.	.	.	.	.
GUAM	.	.	.	.	.
NORTHERN MARIANAS	.	.	.	.	.
PALAU	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
50 STATES & D.C.	0.88	4.18	14.48	17.18	63.28

Population counts are July estimates from the U.S. Bureau of the Census.

Data as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AG1

State Grant Awards Under IDEA, Part B, Preschool Grant Program and Part C

Appropriation Year 1998
Allocation Year 1998-1999

STATE	IDEA, PART B	PRESCHOOL GRANT PROGRAM	PART C
ALABAMA	68,906,291	5,506,321	5,401,820
ALASKA	12,223,506	1,240,996	1,812,075
ARIZONA	61,143,757	5,241,962	6,790,748
ARKANSAS	40,812,654	5,275,780	3,224,319
CALIFORNIA	430,397,584	37,945,640	46,249,617
COLORADO	51,851,905	4,856,958	5,125,020
CONNECTICUT	52,960,246	4,823,971	3,831,379
DELAWARE	11,202,811	1,234,522	1,812,075
DISTRICT OF COLUMBIA	5,632,806	240,026	1,812,075
FLORIDA	238,211,379	18,166,520	17,360,485
GEORGIA	107,489,839	9,602,719	10,497,445
HAWAII	14,182,773	979,916	1,812,075
IDAHO	19,015,033	2,150,606	1,812,075
ILLINOIS	195,787,282	17,371,793	16,098,291
INDIANA	101,144,133	8,751,690	7,501,701
IOWA	48,969,940	3,925,710	3,315,411
KANSAS	40,320,594	4,262,391	3,338,406
KENTUCKY	60,712,428	10,044,866	4,795,769
LOUISIANA	65,731,023	6,382,405	5,747,605
MAINE	21,948,758	2,471,892	1,812,075
MARYLAND	77,078,759	6,570,944	6,237,516
MASSACHUSETTS	113,864,530	9,728,934	8,115,297
MICHIGAN	143,824,267	12,368,808	11,896,386
MINNESOTA	73,287,209	7,305,905	5,792,064
MISSISSIPPI	42,634,586	4,160,974	3,688,050
MISSOURI	90,796,388	5,894,391	6,630,914
MONTANA	12,978,504	1,162,014	1,812,075
NEBRASKA	29,951,455	2,216,202	2,098,289
NEVADA	22,994,298	2,194,131	2,488,044
NEW HAMPSHIRE	18,979,837	1,532,131	1,812,075
NEW JERSEY	144,987,129	11,190,115	9,865,491
NEW MEXICO	35,964,521	3,135,213	2,415,047
NEW YORK	298,216,428	33,194,656	22,590,621
NORTH CAROLINA	114,100,553	11,125,858	9,652,685
NORTH DAKOTA	9,096,547	793,645	1,812,075
OHIO	158,835,881	12,325,761	13,495,119
OKLAHOMA	55,409,503	3,577,925	4,236,413
OREGON	51,655,909	3,779,595	3,969,749
PENNSYLVANIA	156,229,276	13,763,543	12,889,527
PUERTO RICO	37,375,828	3,094,744	5,560,061
RHODE ISLAND	17,540,925	1,643,912	1,812,075
SOUTH CAROLINA	68,345,219	7,022,771	4,638,845
SOUTH DAKOTA	10,836,354	1,441,100	1,812,075
TENNESSEE	88,524,494	6,776,149	6,622,525
TEXAS	335,917,996	22,381,975	29,847,674
UTAH	38,130,825	3,491,974	3,832,145
VERMONT	8,771,498	844,142	1,812,075
VIRGINIA	108,142,698	8,977,259	8,150,863
WASHINGTON	78,773,708	8,034,152	7,047,124
WEST VIRGINIA	30,462,839	3,426,378	1,812,075
WISCONSIN	81,012,476	9,315,949	6,010,473
WYOMING	9,201,446	1,037,066	1,812,075
AMERICAN SAMOA	4,832,745	.	581,948
GUAM	11,675,837	.	1,288,752
NORTHERN MARIANAS	2,980,233	.	387,343
PALAU	.	.	0
VIRGIN ISLANDS	8,852,007	.	759,069
BUR. OF INDIAN AFFAIRS	52,849,182	.	4,567,901
U.S. AND OUTLYING AREAS	4,293,756,632	373,985,000	370,000,001
50 STATES, D.C. & P.R.	4,212,566,628	373,985,000	362,414,988

State grants awards are initial allocations for the 1998 appropriation.

Data as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AH1

Number of Infants and Toddlers Receiving Early Intervention Services
December 1, 1998

STATE	0-1	1-2	2-3	BIRTH THROUGH 2 TOTAL	POPULATION	PERCENTAGE OF POPULATION
ALABAMA	210	608	908	1,726	176,418	0.98
ALASKA	60	174	265	499	29,254	1.71
ARIZONA	436	840	1,005	2,281	221,779	1.03
ARKANSAS	300	703	1,008	2,011	105,303	1.91
CALIFORNIA	3,895	6,518	9,008	19,421	1,510,466	1.29
COLORADO	703	1,080	1,411	3,194	167,378	1.91
CONNECTICUT	482	988	1,957	3,427	125,129	2.74
DELAWARE	168	254	359	781	29,478	2.65
DISTRICT OF COLUMBIA	44	84	121	249	17,842	1.40
FLORIDA	2,760	3,746	5,277	11,783	566,976	2.08
GEORGIA	585	1,304	1,701	3,590	342,836	1.05
HAWAII	1,060	1,022	1,033	3,115	49,331	6.31
IDAHO	218	351	487	1,056	54,824	1.93
ILLINOIS	595	1,616	2,638	4,849	525,754	0.92
INDIANA	1,057	1,912	2,570	5,539	244,998	2.26
IOWA	126	333	505	964	108,278	0.89
KANSAS	302	576	1,006	1,884	108,931	1.73
KENTUCKY	524	1,139	1,710	3,373	156,625	2.15
LOUISIANA	268	585	859	1,712	187,711	0.91
MAINE	65	208	488	761	39,644	1.92
MARYLAND	533	1,278	2,307	4,118	203,711	2.02
MASSACHUSETTS	1,769	3,051	4,983	9,803	233,102	4.21
MICHIGAN	1,293	2,028	2,597	5,918	388,524	1.52
MINNESOTA	382	814	1,561	2,757	189,163	1.46
MISSISSIPPI	435	655	950	2,040	120,448	1.69
MISSOURI	438	793	1,272	2,503	216,559	1.16
MONTANA	141	205	234	580	31,304	1.85
NEBRASKA	70	264	494	828	68,528	1.21
NEVADA	194	387	485	1,066	81,257	1.31
NEW HAMPSHIRE	113	287	490	890	43,008	2.07
NEW JERSEY	499	1,351	2,546	4,396	322,197	1.36
NEW MEXICO	215	402	539	1,156	78,873	1.47
NEW YORK	1,410	4,932	14,250	20,592	737,787	2.79
NORTH CAROLINA	814	1,966	2,221	5,001	315,247	1.59
NORTH DAKOTA	64	99	135	298	24,009	1.24
OHIO	1,122	1,897	2,142	5,161	440,737	1.17
OKLAHOMA	460	737	906	2,103	138,357	1.52
OREGON	231	521	874	1,626	129,648	1.25
PENNSYLVANIA	1,316	2,384	3,685	7,385	420,959	1.75
PUERTO RICO	344	807	1,441	2,592	190,376	1.36
RHODE ISLAND	130	291	566	987	36,694	2.69
SOUTH CAROLINA	361	779	1,054	2,194	151,500	1.45
SOUTH DAKOTA	62	211	322	595	29,897	1.99
TENNESSEE	561	1,145	1,661	3,367	216,285	1.56
TEXAS	1,983	4,338	6,556	12,877	974,795	1.32
UTAH	336	567	925	1,828	125,154	1.46
VERMONT	44	115	222	381	19,070	2.00
VIRGINIA	527	1,203	921	2,651	266,199	1.00
WASHINGTON	275	786	1,382	2,443	230,152	1.06
WEST VIRGINIA	430	573	715	1,718	57,172	3.00
WISCONSIN	469	1,196	2,288	3,953	196,296	2.01
WYOMING	60	125	211	396	18,346	2.16
AMERICAN SAMOA	2	17	24	43	5,052	0.85
GUAM	37	74	120	231	11,464	2.02
NORTHERN MARIANAS	6	13	17	36	3,871	0.93
PALAU	.	.	.	.	1,096	.
VIRGIN ISLANDS	19	30	42	91	5,789	1.57
BUR. OF INDIAN AFFAIRS	483	677	947	2,107	.	.
U.S. AND OUTLYING AREAS	31,486	61,039	96,401	188,926	11,491,581	1.63
50 STATES, D.C. & P.R.	30,939	60,228	95,251	186,418	11,464,309	1.63

Please see data notes for an explanation of individual State differences.

Population figures are July estimates from the Bureau of the Census. Population data for Puerto Rico and the Outlying Areas are projections from the Bureau of Census, International Programs Center. The projections adjust the 1990 Census annually based on the previous year's births and deaths.
Data based on the December 1, 1998 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH2

Number of At-Risk Infants and Toddlers Receiving Early Intervention Services (Duplicated Count) December 1, 1998

STATE	0-1	1-2	2-3	BIRTH THROUGH 2 TOTAL
CALIFORNIA	2,360	4,924	6,453	13,737
HAWAII	813	652	511	1,976
INDIANA	299	255	121	675
MASSACHUSETTS	.	.	.	.
NEW HAMPSHIRE	5	5	10	20
NEW MEXICO	.	.	.	.
NORTH CAROLINA	219	530	600	1,349
WEST VIRGINIA	17	40	36	93
GUAM	2	4	4	10
U.S. AND OUTLYING AREAS	3,715	6,410	7,735	17,860

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1998 count, Updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

In 1998, OSEP first required States to separately report at-risk infants and toddlers.

Table AH3

Number of Infants and Toddlers Ages Birth Through 2 Served Under IDEA, Part C by Race/Ethnicity During the 1998-99 School Year

STATE	AMERICAN INDIAN/ALASKAN	ASIAN/ PACIFIC ISLANDER	BLACK	HISPANIC	WHITE	MISSING
ALABAMA	10	6	754	29	927	0
ALASKA	185	22	30	24	238	0
ARIZONA	200	27	121	783	1,150	0
ARKANSAS	1	9	761	60	1,180	0
CALIFORNIA	56	844	1,734	6,544	5,263	4,980
COLORADO	27	86	198	796	2,087	0
CONNECTICUT	11	83	499	577	2,257	0
DELAWARE	2	9	224	71	448	27
DISTRICT OF COLUMBIA	0	2	205	37	5	0
FLORIDA	14	75	3,126	1,653	6,915	0
GEORGIA	4	44	1,377	216	1,919	30
HAWAII	7	2,612	84	79	333	0
IDAHO	11	1	5	137	876	26
ILLINOIS	3	78	1,115	647	3,006	0
INDIANA	4	56	585	140	4,754	0
IOWA	8	12	57	43	844	0
KANSAS	15	36	192	224	1,417	0
KENTUCKY	0	0	0	0	0	0
LOUISIANA	14	16	795	22	865	0
MAINE	5	7	4	3	742	0
MARYLAND	4	105	1,208	130	2,057	614
MASSACHUSETTS	32	303	851	1,840	6,777	0
MICHIGAN	60	83	1,302	225	4,248	0
MINNESOTA	71	51	196	95	2,344	0
MISSISSIPPI	5	1	1,367	4	663	0
MISSOURI	31	19	374	32	2,047	0
MONTANA	122	8	5	19	426	0
NEBRASKA	14	10	60	47	697	0
NEVADA	16	52	115	245	638	0
NEW HAMPSHIRE	7	10	10	17	841	5
NEW JERSEY	6	143	931	621	2,695	0
NEW MEXICO	195	6	25	541	389	0
NEW YORK	24	199	1,415	993	7,159	10,802
NORTH CAROLINA	75	124	2,000	201	2,601	0
NORTH DAKOTA	45	3	6	7	237	0
OHIO	11	49	835	121	3,933	212
OKLAHOMA	171	28	256	91	1,557	0
OREGON	35	31	30	197	1,333	0
PENNSYLVANIA	16	50	1,133	338	4,916	932
PUERTO RICO	0	1	0	2,591	0	0
RHODE ISLAND	5	11	72	161	738	0
SOUTH CAROLINA	2	13	1,056	37	1,086	0
SOUTH DAKOTA	174	2	11	4	404	0
TENNESSEE	10	43	559	73	2,352	330
TEXAS	18	251	1,826	5,030	5,269	483
UTAH	103	44	26	148	1,504	3
VERMONT	6	9	6	8	352	0
VIRGINIA	5	52	726	146	1,722	0
WASHINGTON	69	60	115	352	1,597	250
WEST VIRGINIA	2	3	30	1	1,682	0
WISCONSIN	52	85	754	209	2,853	0
WYOMING	23	2	7	35	329	0
AMERICAN SAMOA	0	43	0	0	0	0
GUAM	7	173	16	15	20	0
NORTHERN MARIANAS	0	35	0	0	1	0
PALAU	0	0	0	0	0	0
VIRGIN ISLANDS	0	0	74	14	3	0
BUR. OF INDIAN AFFAIRS	2,107	0	0	0	0	0
U.S. AND OUTLYING AREAS	4,100	6,127	29,263	26,673	100,696	18,694
50 STATES, D.C. & P.R.	1,986	5,876	29,173	26,644	100,672	18,694

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH3

Percentage of Infants and Toddlers Ages Birth Through 2 Served Under IDEA, Part C by Race/Ethnicity During the 1998-99 School Year

STATE	AMERICAN INDIAN/ALASKAN	ASIAN/ PACIFIC ISLANDER	BLACK	HISPANIC	WHITE
ALABAMA	0.58	0.35	43.68	1.68	53.71
ALASKA	37.07	4.41	6.01	4.81	47.70
ARIZONA	8.77	1.18	5.30	34.33	50.42
ARKANSAS	0.05	0.45	37.84	2.98	58.68
CALIFORNIA	0.39	5.84	12.01	45.32	36.44
COLORADO	0.85	2.69	6.20	24.92	65.34
CONNECTICUT	0.32	2.42	14.56	16.84	65.86
DELAWARE	0.27	1.19	29.71	9.42	59.42
DISTRICT OF COLUMBIA	0.00	0.80	82.33	14.86	2.01
FLORIDA	0.12	0.64	26.53	14.03	58.69
GEORGIA	0.11	1.24	38.68	6.07	53.90
HAWAII	0.22	83.85	2.70	2.54	10.69
IDAHO	1.07	0.10	0.49	13.30	85.05
ILLINOIS	0.06	1.61	22.99	13.34	61.99
INDIANA	0.07	1.01	10.56	2.53	85.83
IOWA	0.83	1.24	5.91	4.46	87.55
KANSAS	0.80	1.91	10.19	11.89	75.21
KENTUCKY	0.00	0.00	0.00	0.00	0.00
LOUISIANA	0.82	0.93	46.44	1.29	50.53
MAINE	0.66	0.92	0.53	0.39	97.50
MARYLAND	0.11	3.00	34.47	3.71	58.70
MASSACHUSETTS	0.33	3.09	8.68	18.77	69.13
MICHIGAN	1.01	1.40	22.00	3.80	71.78
MINNESOTA	2.58	1.85	7.11	3.45	85.02
MISSISSIPPI	0.25	0.05	67.01	0.20	32.50
MISSOURI	1.24	0.76	14.94	1.28	81.78
MONTANA	21.03	1.38	0.86	3.28	73.45
NEBRASKA	1.69	1.21	7.25	5.68	84.18
NEVADA	1.50	4.88	10.79	22.98	59.85
NEW HAMPSHIRE	0.79	1.13	1.13	1.92	95.03
NEW JERSEY	0.14	3.25	21.18	14.13	61.31
NEW MEXICO	16.87	0.52	2.16	46.80	33.65
NEW YORK	0.25	2.03	14.45	10.14	73.13
NORTH CAROLINA	1.50	2.48	39.99	4.02	52.01
NORTH DAKOTA	15.10	1.01	2.01	2.35	79.53
OHIO	0.22	0.99	16.87	2.44	79.47
OKLAHOMA	8.13	1.33	12.17	4.33	74.04
OREGON	2.15	1.91	1.85	12.12	81.98
PENNSYLVANIA	0.25	0.77	17.56	5.24	76.18
PUERTO RICO	0.00	0.04	0.00	99.96	0.00
RHODE ISLAND	0.51	1.11	7.29	16.31	74.77
SOUTH CAROLINA	0.09	0.59	48.13	1.69	49.50
SOUTH DAKOTA	29.24	0.34	1.85	0.67	67.90
TENNESSEE	0.33	1.42	18.41	2.40	77.44
TEXAS	0.15	2.03	14.73	40.58	42.51
UTAH	5.64	2.41	1.42	8.11	82.41
VERMONT	1.57	2.36	1.57	2.10	92.39
VIRGINIA	0.19	1.96	27.39	5.51	64.96
WASHINGTON	3.15	2.74	5.24	16.05	72.82
WEST VIRGINIA	0.12	0.17	1.75	0.06	97.90
WISCONSIN	1.32	2.15	19.07	5.29	72.17
WYOMING	5.81	0.51	1.77	8.84	83.08
AMERICAN SAMOA	0.00	100.00	0.00	0.00	0.00
GUAM	3.03	74.89	6.93	6.49	8.66
NORTHERN MARIANAS	0.00	97.22	0.00	0.00	2.78
PALAU	0.00	0.00	0.00	0.00	0.00
VIRGIN ISLANDS	0.00	0.00	81.32	15.38	3.30
BUR. OF INDIAN AFFAIRS	100.00	0.00	0.00	0.00	0.00
U.S. AND OUTLYING AREAS	2.46	3.67	17.54	15.99	60.35
50 STATES, D.C. & P.R.	1.21	3.58	17.75	16.21	61.25

Percentages are based on the number of infants and toddlers for whom race/ethnicity data were known.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AH3

Number of Infants and Toddlers Ages Birth Through 2 Served Under IDEA, Part C by Race/Ethnicity: At Risk December 1, 1998

STATE	AMERICAN INDIAN/ALASKAN	ASIAN/ PACIFIC ISLANDER	BLACK	HISPANIC	WHITE	MISSING
CALIFORNIA	31	566	1,232	4,226	3,313	4,369
HAWAII	2	1,773	48	39	114	0
INDIANA	0	2	99	16	558	0
MASSACHUSETTS	0	0	0	0	0	0
NEW HAMPSHIRE	1	0	0	2	16	1
NEW MEXICO	0	0	0	0	0	0
NORTH CAROLINA	21	34	540	55	700	-1
WEST VIRGINIA	0	0	6	0	87	0
GUAM	0	10	0	0	0	0
U.S. AND OUTLYING AREAS	55	2,385	1,925	4,338	4,788	4,369

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AH3

Percentage of Infants and Toddlers Ages Birth Through 2 Served Under IDEA, Part C by Race/Ethnicity: At Risk December 1, 1998

STATE	AMERICAN INDIAN/ALASKAN	ASIAN/ PACIFIC ISLANDER	BLACK	HISPANIC	WHITE
CALIFORNIA	0.33	6.04	13.15	45.11	35.37
HAWAII	0.10	89.73	2.43	1.97	5.77
INDIANA	0.00	0.30	14.67	2.37	82.67
MASSACHUSETTS	0.00	0.00	0.00	0.00	0.00
NEW HAMPSHIRE	5.26	0.00	0.00	10.53	84.21
NEW MEXICO	0.00	0.00	0.00	0.00	0.00
NORTH CAROLINA	1.56	2.52	40.00	4.07	51.85
WEST VIRGINIA	0.00	0.00	6.45	0.00	93.55
GUAM	0.00	100.00	0.00	0.00	0.00
U.S. AND OUTLYING AREAS	0.41	17.68	14.27	32.15	35.49

Percentages are based on the number of infants and toddlers for whom race/ethnicity data were known.

Data based on the December 1, 1998 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AH4

Percentage of Infants and Toddlers Ages Birth Through 2 Served Under IDEA, Part C by Race/Ethnicity, Based on Estimated Population During the 1998-99 School Year

STATE	AMERICAN INDIAN/ALASKAN	ASIAN/ PACIFIC ISLANDER	BLACK	HISPANIC	WHITE
ALABAMA	2.93	0.37	1.39	0.92	0.79
ALASKA	2.59	1.64	2.58	1.37	1.33
ARIZONA	1.57	0.63	2.12	0.95	0.99
ARKANSAS	0.14	0.81	3.58	1.71	1.50
CALIFORNIA	1.12	0.53	2.05	0.94	0.93
COLORADO	2.59	1.72	3.21	1.93	1.83
CONNECTICUT	5.88	2.07	4.11	3.02	2.52
DELAWARE	6.25	1.31	3.42	3.83	2.20
DISTRICT OF COLUMBIA	0.00	0.50	1.51	2.21	0.23
FLORIDA	0.93	0.61	2.77	1.59	2.06
GEORGIA	0.76	0.60	1.26	1.33	0.92
HAWAII	2.87	8.19	8.04	1.27	3.35
IDAHO	1.75	0.13	2.78	1.91	1.90
ILLINOIS	0.66	0.41	1.21	0.71	0.93
INDIANA	1.10	1.81	2.48	1.42	2.28
IOWA	2.59	0.52	2.12	1.04	0.85
KANSAS	2.18	1.38	2.74	2.09	1.61
KENTUCKY	.	.	.	.	.
LOUISIANA	1.93	0.51	1.09	0.37	0.82
MAINE	2.18	1.34	1.66	0.52	1.95
MARYLAND	0.89	1.12	1.86	1.21	1.74
MASSACHUSETTS	5.96	1.91	4.07	6.44	4.05
MICHIGAN	2.91	1.00	2.05	1.14	1.44
MINNESOTA	2.46	0.57	2.31	1.34	1.45
MISSISSIPPI	0.88	0.09	2.57	0.27	1.03
MISSOURI	5.35	0.53	1.25	0.55	1.16
MONTANA	3.54	2.48	5.10	1.60	1.62
NEBRASKA	1.55	0.68	1.85	0.92	1.21
NEVADA	1.69	1.23	2.17	1.19	1.27
NEW HAMPSHIRE	11.48	1.55	3.76	1.56	2.05
NEW JERSEY	1.27	0.60	1.90	1.11	1.40
NEW MEXICO	2.32	0.58	2.48	1.28	1.49
NEW YORK	1.65	0.42	1.27	0.59	1.75
NORTH CAROLINA	1.57	1.90	2.65	1.47	1.21
NORTH DAKOTA	2.06	0.82	2.14	1.17	1.15
OHIO	1.36	0.63	1.26	0.97	1.11
OKLAHOMA	1.13	1.08	1.86	0.88	1.61
OREGON	2.31	0.55	1.29	1.29	1.27
PENNSYLVANIA	3.54	0.49	2.24	1.59	1.45
PUERTO RICO	.	.	.	.	.
RHODE ISLAND	1.57	0.89	3.96	3.44	2.58
SOUTH CAROLINA	0.61	0.70	2.09	1.07	1.14
SOUTH DAKOTA	3.73	0.67	4.68	0.55	1.69
TENNESSEE	2.61	1.34	1.25	1.72	1.44
TEXAS	1.13	0.95	1.85	1.18	1.25
UTAH	6.61	1.08	3.53	1.22	1.41
VERMONT	18.18	4.41	9.09	3.90	1.90
VIRGINIA	1.20	0.41	1.28	0.92	0.95
WASHINGTON	1.67	0.36	1.49	1.28	0.92
WEST VIRGINIA	4.44	0.58	1.27	0.15	3.14
WISCONSIN	2.23	1.38	4.69	2.10	1.76
WYOMING	3.99	1.02	6.25	1.76	2.13
AMERICAN SAMOA	.	.	.	.	.
GUAM	.	.	.	.	.
NORTHERN MARIANAS	.	.	.	.	.
PALAU	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
50 STATES & D.C.	2.04	1.18	1.89	1.17	1.42

Please see data notes for an explanation of individual State differences.
The sum of the percentages of individual disabilities may not equal the percentage of all disabilities because of rounding.
Resident population data are provided from Population Estimates Program, Population Division U.S. Census Bureau for July 1998.
The percentage is based on the number of people within the specific race/ethnicity category in the resident population.
Data based on the December 1, 1998 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH5

Early Intervention Services on IFSPs Provided to Infants, Toddlers, and Their Families in Accord with Part C
December 1, 1997

STATE	ASSISTIVE TECHNOLOGY SERVICES/ DEVICES	AUDIOLOGY	FAMILY TRAINING COUNSELING AND HOME VISITS	HEALTH SERVICES	MEDICAL SERVICES	NURSING SERVICES
ALABAMA	62	216	695	63	207	324
ALASKA	2	99	14	111	203	62
ARIZONA	4	87	411	14	75	43
ARKANSAS	67	527	1,274	252	269	230
CALIFORNIA	75	182	2,030	1,230	24	190
COLORADO	131	229	1,227	513	552	218
CONNECTICUT	1	24	72	.	.	18
DELAWARE	7	40	48	39	301	123
DISTRICT OF COLUMBIA	21	26	167	30	37	158
FLORIDA	848	464	7,940	175	4,913	3,106
GEORGIA	283	279	189	70	121	136
HAWAII	70	75	1,801	170	20	388
IDAHO	69	104	145	46	271	100
ILLINOIS	282	721	1,500	267	177	777
INDIANA	358	74	333	9	7	32
IOWA	29	167	78	38	31	95
KANSAS	272	345	668	329	146	126
KENTUCKY	247	240	83	66	872	149
LOUISIANA	68	395	123	168	483	154
MAINE	24	13	20	24	11	.
MARYLAND	7	583	146	20	18	337
MASSACHUSETTS	.	289	9,645	9,645	0	781
MICHIGAN	107	281	1,413	1,607	553	1,259
MINNESOTA	207	370	571	280	392	500
MISSISSIPPI	80	346	383	0	68	0
MISSOURI	215	170	559	2	351	68
MONTANA	48	121	531	78	154	33
NEBRASKA	6	60	50	19	5	19
NEVADA	12	47	944	125	375	0
NEW HAMPSHIRE	.	0	259	1	2	5
NEW JERSEY	34	136	298	4	55	56
NEW MEXICO	566	970	1,204	673	999	455
NEW YORK	349	126	4,592	1	89	166
NORTH CAROLINA	224	824	995	288	1,460	331
NORTH DAKOTA	52	54	326	55	66	29
OHIO	68	401	3,648	834	776	703
OKLAHOMA	0	7	15	0	0	56
OREGON	10	56	255	43	.	.
PENNSYLVANIA	72	251	535	5	3	251
PUERTO RICO	232	1,122	739	850	4,272	4,272
RHODE ISLAND	4	99	195	1	4	6
SOUTH CAROLINA	58	241	96	19	165	87
SOUTH DAKOTA	15	13	40	2	5	6
TENNESSEE	277	682	1,726	494	575	744
TEXAS	1,349	1,051	3,951	125	577	295
UTAH	53	177	1,325	82	19	576
VERMONT	8	41	75	.	46	24
VIRGINIA	62	91	156	25	50	36
WASHINGTON	292	277	1,435	401	512	415
WEST VIRGINIA	3	69	99	10	30	154
WISCONSIN	132	214	466	35	86	311
WYOMING	19	104	275	42	84	14
AMERICAN SAMOA	48	48	48	48	48	48
GUAM	0	103	227	0	0	22
NORTHERN MARIANAS	8	24	37	3	5	9
PALAU	0	0	6	0	0	0
VIRGIN ISLANDS	0	11	18	1	33	0
U.S. AND OUTLYING AREAS	7,537	13,766	56,101	19,432	20,597	18,497
50 STATES, D.C. & P.R.	7,481	13,580	55,765	19,380	20,511	18,418

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1997 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AH5

Early Intervention Services on IFSPs Provided to Infants, Toddlers, and Their Families in Accord with Part C
December 1, 1997

STATE	NUTRITION SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	PSYCHOLOGICAL SERVICES	RESPITE CARE	SOCIAL WORK SERVICES
ALABAMA	132	945	1,110	70	.	242
ALASKA	89	140	180	6	58	37
ARIZONA	70	803	823	4	311	13
ARKANSAS	175	787	834	269	17	106
CALIFORNIA	28	1,271	913	2,030	1,425	2,030
COLORADO	285	685	630	52	369	238
CONNECTICUT	16	642	874	11	.	142
DELAWARE	114	196	237	12	2	76
DISTRICT OF COLUMBIA	164	167	163	100	12	148
FLORIDA	0	3,040	3,473	1,034	0	20,667
GEORGIA	195	1,225	1,483	77	658	76
HAWAII	318	274	283	207	13	729
IDAHO	193	368	189	185	9	302
ILLINOIS	333	1,166	1,130	406	167	790
INDIANA	51	2,110	2,417	17	0	53
IOWA	35	318	364	45	33	79
KANSAS	284	670	652	252	110	329
KENTUCKY	59	1,190	1,473	59	583	46
LOUISIANA	187	422	483	1	28	42
MAINE	6	153	261	3	.	24
MARYLAND	14	955	.	85	6	55
MASSACHUSETTS	192	984	887	598	.	1,215
MICHIGAN	584	1,638	1,466	222	184	3,093
MINNESOTA	143	1,319	934	110	308	655
MISSISSIPPI	37	82	74	13	210	102
MISSOURI	61	839	940	7	0	42
MONTANA	97	171	185	40	301	71
NEBRASKA	.	330	333	29	.	40
NEVADA	149	238	319	263	12	374
NEW HAMPSHIRE	15	348	281	0	10	75
NEW JERSEY	31	852	1,327	43	2	384
NEW MEXICO	734	1,044	1,064	363	609	759
NEW YORK	157	6,340	7,374	368	1,521	1,147
NORTH CAROLINA	779	860	1,661	162	437	658
NORTH DAKOTA	83	142	56	16	58	54
OHIO	999	1,268	1,472	52	396	703
OKLAHOMA	17	284	428	25	0	2
OREGON	.	557	588	3	.	12
PENNSYLVANIA	59	2,430	2,945	171	0	591
PUERTO RICO	873	1,125	1,119	966	3	2,652
RHODE ISLAND	94	210	249	25	0	10
SOUTH CAROLINA	654	601	750	81	8	37
SOUTH DAKOTA	14	206	243	3	0	0
TENNESSEE	578	719	1,087	152	14	1,106
TEXAS	1,076	3,986	3,166	185	91	800
UTAH	101	490	544	0	0	65
VERMONT	38	85	110	8	42	24
VIRGINIA	40	728	1,223	10	159	55
WASHINGTON	515	1,059	898	226	53	616
WEST VIRGINIA	183	645	1,064	189	4	177
WISCONSIN	93	1,788	1,566	27	.	871
WYOMING	55	187	182	57	32	87
AMERICAN SAMOA	48	48	46	48	0	48
GUAM	14	26	72	107	0	31
NORTHERN MARIANAS	5	30	29	0	0	1
PALAU	0	0	0	0	0	0
VIRGIN ISLANDS	5	25	35	0	9	18
U.S. AND OUTLYING AREAS	11,271	49,211	52,689	9,494	8,469	42,799
50 STATES, D.C. & P.R.	11,199	49,082	52,507	9,339	8,460	42,701

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1997 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH5

Early Intervention Services on IFSPs Provided to Infants, Toddlers, and Their Families in Accord with Part C
December 1, 1997

STATE	SPECIAL INSTRUCTION	SPEECH LANGUAGE PATHOLOGY	TRANSPOR-TATION	VISION SERVICES	OTHER EARLY INTERVEN-TION SERVICES
ALABAMA	853	1,384	267	159	.
ALASKA	441	185	7	29	1
ARIZONA	1,277	825	132	28	16
ARKANSAS	1,274	1,279	791	285	71
CALIFORNIA	10,106	2,058	852	224	.
COLORADO	1,448	605	265	162	512
CONNECTICUT	1,700	1,322	21	11	161
DELAWARE	313	294	62	88	239
DISTRICT OF COLUMBIA	205	158	197	22	63
FLORIDA	0	5,007	2,221	852	19,677
GEORGIA	1,622	1,501	1,106	217	30
HAWAII	601	411	406	87	0
IDAHO	521	408	78	48	975
ILLINOIS	2,338	1,836	526	236	424
INDIANA	4,715	2,858	1,049	19	16
IOWA	843	307	66	40	40
KANSAS	1,155	1,109	247	197	65
KENTUCKY	1,763	1,722	320	118	.
LOUISIANA	1,227	314	34	380	540
MAINE	.	358	272	7	.
MARYLAND	.	.	486	153	11
MASSACHUSETTS	2,218	1,447	2,507	578	.
MICHIGAN	1,779	1,362	596	161	1,571
MINNESOTA	2,148	1,507	238	198	276
MISSISSIPPI	907	641	14	17	4
MISSOURI	938	988	745	101	2,312
MONTANA	103	196	46	61	531
NEBRASKA	885	415	100	8	71
NEVADA	944	330	0	31	944
NEW HAMPSHIRE	140	403	6	75	435
NEW JERSEY	2,920	1,566	97	167	126
NEW MEXICO	1,118	1,188	798	380	1,555
NEW YORK	9,902	13,922	5,662	308	0
NORTH CAROLINA	2,415	1,446	656	566	927
NORTH DAKOTA	250	158	16	59	3
OHIO	1,702	1,561	743	160	7,083
OKLAHOMA	458	599	0	8	60
OREGON	.	811	282	.	.
PENNSYLVANIA	4,324	3,376	454	293	6,944
PUERTO RICO	2,018	1,085	365	333	0
RHODE ISLAND	328	265	83	5	562
SOUTH CAROLINA	1,240	738	34	289	283
SOUTH DAKOTA	350	291	145	13	0
TENNESSEE	1,718	1,303	909	278	352
TEXAS	8,249	5,590	310	745	220
UTAH	767	822	421	142	9
VERMONT	190	164	19	16	.
VIRGINIA	1,027	1,003	134	51	63
WASHINGTON	1,709	1,393	436	186	76
WEST VIRGINIA	1,875	1,159	304	70	.
WISCONSIN	2,457	2,674	1,084	93	54
WYOMING	247	224	103	33	1
AMERICAN SAMOA	48	48	48	48	48
GUAM	71	47	32	0	12
NORTHERN MARIANAS	37	22	6	4	21
PALAU	0	0	0	0	0
VIRGIN ISLANDS	0	43	1	7	9
U.S. AND OUTLYING AREAS	87,884	72,728	26,799	8,846	47,393
50 STATES, D.C. & P.R.	87,728	72,568	26,712	8,787	47,303

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1997 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Table AH6

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1997

STATE	ALL STAFF		AUDIOLOGISTS		FAMILY THERAPISTS	
	EMPLOYED	NEEDED	EMPLOYED	NEEDED	EMPLOYED	NEEDED
ALABAMA	251	41	0	0	0	1
ALASKA	96	.	1	.	0	.
ARIZONA	307	98	0	0	6	10
ARKANSAS	1,163	.	8	.	1	.
CALIFORNIA	.	.	.	.	.	.
COLORADO	.	.	.	.	.	.
CONNECTICUT	381	32	7	0	3	0
DELAWARE	194	4	1	0	2	0
DISTRICT OF COLUMBIA	187	41	3	2	3	2
FLORIDA	4,836	.	95	.	0	.
GEORGIA	561	224	17	8	8	8
HAWAII	294	53	1	1	0	2
IDAHO	138	128	0	1	0	.
ILLINOIS	482	152	4	3	9	3
INDIANA	733	0	3	0	0	0
IOWA	211	48	7	2	2	1
KANSAS	282	22	3	0	0	1
KENTUCKY	1,191	.	23	.	8	.
LOUISIANA	321	86	4	2	6	0
MAINE	351	.	45	.	8	.
MARYLAND	426	8	6	0	3	0
MASSACHUSETTS	1,010	1,080	0	0	0	0
MICHIGAN	937	0	10	0	13	0
MINNESOTA	492	22	4	0	1	1
MISSISSIPPI	36	51	3	4	1	2
MISSOURI	145	.	4	.	2	.
MONTANA	87	4	0	0	3	0
NEBRASKA	243	0	0	0	.	.
NEVADA	92	7	2	0	0	0
NEW HAMPSHIRE	119	2	0	0	4	0
NEW JERSEY	345	21	0	0	0	0
NEW MEXICO	202	14	0	0	7	0
NEW YORK	8,841	900	134	15	.	.
NORTH CAROLINA	1,078	71	18	2	13	5
NORTH DAKOTA	29	0	1	0	0	0
OHIO	2,258	0	14	0	18	0
OKLAHOMA	124	93	2	1	0	0
OREGON	195	40	1	0	7	0
PENNSYLVANIA	1,053	148	10	3	3	0
PUERTO RICO	192	15	5	1	0	0
RHODE ISLAND	70	.	0	.	0	.
SOUTH CAROLINA	244	.	1	.	8	.
SOUTH DAKOTA	84	.	0	.	.	.
TENNESSEE	613	68	8	.	1	.
TEXAS	1,413	94	5	0	3	0
UTAH	162	16	1	1	1	0
VERMONT	58	16	1	0	0	0
VIRGINIA	442	92	10	1	0	0
WASHINGTON	537	.	7	.	10	.
WEST VIRGINIA	268	.	1	.	5	.
WISCONSIN	520	12	1	.	4	.
WYOMING	145	112	6	6	4	9
AMERICAN SAMOA	40	.	1	.	1	.
GUAM	22	33	1	1	0	0
NORTHERN MARIANAS	16	7	0	0	0	0
PALAU	2	2	0	0	0	0
VIRGIN ISLANDS	9	3	1	0	0	0
U.S. AND OUTLYING AREAS	34,528	3,859	480	53	168	45
50 STATES, D.C. & P.R.	34,439	3,814	477	52	167	45

Please see data notes for an explanation of individual State differences.
The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because (1)some States could not provide personnel data by category and (2)rounding.
Data based on the December 1, 1997 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH6

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1997

STATE	NURSES		NUTRITIONISTS		OCCUPATIONAL THERAPISTS	
	EMPLOYED	NEEDED	EMPLOYED	NEEDED	EMPLOYED	NEEDED
ALABAMA	5	2	1	2	13	4
ALASKA	3	.	0	.	9	.
ARIZONA	41	2	24	34	27	3
ARKANSAS	114	.	7	.	78	.
CALIFORNIA	.	.	.	.	.	.
COLORADO	.	.	.	.	.	.
CONNECTICUT	6	0	3	0	34	5
DELAWARE	55	0	1	0	11	0
DISTRICT OF COLUMBIA	13	3	3	1	12	5
FLORIDA	262	.	17	.	588	.
GEORGIA	41	9	11	6	63	13
HAWAII	33	1	2	0	12	4
IDAHO	3	0	1	1	9	13
ILLINOIS	28	9	1	2	33	18
INDIANA	3	0	1	0	83	0
IOWA	10	3	2	2	14	4
KANSAS	14	1	3	0	18	2
KENTUCKY	14	.	6	.	105	.
LOUISIANA	1	2	1	0	26	8
MAINE	48	.	5	.	14	.
MARYLAND	26	1	0	0	34	1
MASSACHUSETTS	82	88	3	3	104	111
MICHIGAN	118	0	5	0	88	0
MINNESOTA	37	2	2	0	59	3
MISSISSIPPI	2	3	0	1	1	2
MISSOURI	1	.	2	.	17	.
MONTANA	3	0	1	0	4	0
NEBRASKA	2	0	.	.	6	0
NEVADA	0	0	4	0	4	0
NEW HAMPSHIRE	2	0	0	0	24	1
NEW JERSEY	18	0	0	0	32	1
NEW MEXICO	4	0	1	0	10	3
NEW YORK	1,188	54	83	16	1,009	135
NORTH CAROLINA	56	3	9	0	33	6
NORTH DAKOTA	0	0	0	0	6	0
OHIO	284	0	32	0	119	0
OKLAHOMA	8	1	1	0	18	2
OREGON	2	1	0	1	13	3
PENNSYLVANIA	8	3	2	2	131	20
PUERTO RICO	28	0	4	3	28	.
RHODE ISLAND	1	.	0	.	2	.
SOUTH CAROLINA	14	.	1	.	3	.
SOUTH DAKOTA	3	.	0	.	9	.
TENNESSEE	42	1	3	0	30	11
TEXAS	78	2	11	0	120	6
UTAH	19	2	0	1	7	2
VERMONT	4	0	2	0	4	2
VIRGINIA	37	8	7	2	42	6
WASHINGTON	21	.	9	.	74	.
WEST VIRGINIA	10	.	3	.	8	.
WISCONSIN	12	.	1	.	79	2
WYOMING	5	5	6	3	15	9
AMERICAN SAMOA	3	.	2	.	1	.
GUAM	4	4	0	1	0	1
NORTHERN MARIANAS	0	1	0	0	1	1
PALAU	0	0	0	0	0	0
VIRGIN ISLANDS	2	0	0	0	0	0
U.S. AND OUTLYING AREAS	2,816	211	282	81	3,283	405
50 STATES, D.C. & P.R.	2,807	206	280	80	3,282	403

Please see data notes for an explanation of individual State differences.
The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because (1)some States could not provide personnel data by category and (2)rounding.
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Table AH6

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families
December 1, 1997

STATE	ORIENTATION AND MOBILITY SPECIALISTS EMPLOYED	ORIENTATION AND MOBILITY SPECIALISTS NEEDED	PARAPROFESSIONALS EMPLOYED	PARAPROFESSIONALS NEEDED	PEDIATRICIANS EMPLOYED	PEDIATRICIANS NEEDED
ALABAMA	0	2	57	5	0	0
ALASKA	0	.	13	.	0	.
ARIZONA	0	0	36	16	0	0
ARKANSAS	1	.	357	.	5	.
CALIFORNIA	.	.	.	.	.	.
COLORADO	.	.	.	.	.	.
CONNECTICUT	3	0	46	2	2	0
DELAWARE	0	0	36	1	9	0
DISTRICT OF COLUMBIA	1	0	67	1	3	2
FLORIDA	0	.	124	.	689	.
GEORGIA	4	6	96	24	17	28
HAWAII	0	0	162	28	0	0
IDAHO	1	.	29	61	1	.
ILLINOIS	0	0	44	7	20	1
INDIANA	0	0	48	0	0	0
IOWA	1	1	5	2	.	.
KANSAS	0	0	74	3	2	0
KENTUCKY	.	.	587	.	.	.
LOUISIANA	0	0	51	17	0	0
MAINE	1	.	23	.	12	.
MARYLAND	0	0	42	0	4	0
MASSACHUSETTS	.	.	90	96	1	1
MICHIGAN	2	0	27	0	9	0
MINNESOTA	1	0	31	1	.	.
MISSISSIPPI	0	1	6	7	0	1
MISSOURI	2	.	15	.	5	.
MONTANA	0	0	7	0	0	0
NEBRASKA	.	.	99	0	.	.
NEVADA	0	0	14	1	3	0
NEW HAMPSHIRE	0	0	13	0	0	0
NEW JERSEY	0	0	33	2	0	0
NEW MEXICO	0	0	17	1	0	0
NEW YORK	23	7	374	70	.	.
NORTH CAROLINA	9	1	187	7	11	1
NORTH DAKOTA	0	0	0	0	0	0
OHIO	0	0	0	0	0	0
OKLAHOMA	0	0	0	0	0	0
OREGON	2	0	41	10	0	0
PENNSYLVANIA	8	2	55	7	1	0
PUERTO RICO	0	0	33	3	16	0
RHODE ISLAND	0	.	7	.	0	.
SOUTH CAROLINA	2	.	31	.	1	.
SOUTH DAKOTA	0	.	.	.	0	.
TENNESSEE	0	.	136	8	1	.
TEXAS	2	0	183	29	4	0
UTAH	0	0	38	0	0	0
VERMONT	0	0	5	5	1	0
VIRGINIA	4	1	30	10	8	3
WASHINGTON	1	.	74	.	11	.
WEST VIRGINIA	0	.	47	.	2	.
WISCONSIN	1	.	82	2	0	.
WYOMING	0	2	14	15	16	4
AMERICAN SAMOA	0	.	1	.	7	.
GUAM	0	0	4	8	0	0
NORTHERN MARIANAS	0	1	4	0	0	0
PALAU	0	0	0	0	0	0
VIRGIN ISLANDS	0	0	1	0	2	1
U.S. AND OUTLYING AREAS	73	24	3,596	446	862	42
50 STATES, D.C. & P.R.	73	23	3,586	438	854	41

Please see data notes for an explanation of individual State differences.
The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because (1)some States could not provide personnel data by category and (2)rounding.
Data based on the December 1, 1997 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH6

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1997

STATE	PHYSICAL THERAPISTS EMPLOYED	PHYSICAL THERAPISTS NEEDED	PHYSICIANS, OTHER THAN PEDIATRICIANS EMPLOYED	PHYSICIANS, OTHER THAN PEDIATRICIANS NEEDED	PSYCHOLOGISTS EMPLOYED	PSYCHOLOGISTS NEEDED
ALABAMA	15	4	0	0	0	0
ALASKA	9	.	0	.	1	.
ARIZONA	36	8	1	0	5	0
ARKANSAS	92	.	12	.	10	.
CALIFORNIA	.	.	.	.	.	.
COLORADO	.	.	.	.	.	.
CONNECTICUT	45	6	2	0	3	0
DELAWARE	11	0	0	0	1	0
DISTRICT OF COLUMBIA	11	3	2	0	7	1
FLORIDA	549	.	303	.	145	.
GEORGIA	77	28	16	24	20	14
HAWAII	8	4	0	0	1	1
IDAHO	4	5	1	.	3	0
ILLINOIS	34	21	2	2	6	5
INDIANA	102	0	0	0	1	0
IOWA	13	3	0	.	14	5
KANSAS	15	2	2	0	3	1
KENTUCKY	120	.	.	.	6	.
LOUISIANA	18	9	0	0	12	2
MAINE	25	.	6	.	0	.
MARYLAND	58	1	0	0	7	0
MASSACHUSETTS	93	100	0	0	63	67
MICHIGAN	60	0	34	0	28	0
MINNESOTA	34	1	.	.	8	1
MISSISSIPPI	4	5	0	1	0	1
MISSOURI	19	.	11	.	0	.
MONTANA	6	1	1	0	0	0
NEBRASKA	3	0	.	.	1	0
NEVADA	5	0	0	0	5	1
NEW HAMPSHIRE	18	0	0	0	0	0
NEW JERSEY	35	0	1	0	1	0
NEW MEXICO	11	2	1	0	1	0
NEW YORK	1,153	121	262	14	449	63
NORTH CAROLINA	47	4	0	0	43	5
NORTH DAKOTA	0	0	0	0	0	0
OHIO	135	0	54	0	38	0
OKLAHOMA	18	6	0	0	3	0
OREGON	13	3	0	0	1	1
PENNSYLVANIA	124	22	1	0	6	0
PUERTO RICO	25	.	0	0	9	2
RHODE ISLAND	3	.	0	.	1	.
SOUTH CAROLINA	5	.	1	.	1	.
SOUTH DAKOTA	14	.	0	.	0	.
TENNESSEE	41	15	4	0	1	.
TEXAS	82	11	2	0	2	0
UTAH	9	2	0	0	1	0
VERMONT	6	2	0	0	1	1
VIRGINIA	52	7	3	2	3	2
WASHINGTON	70	.	4	.	3	.
WEST VIRGINIA	13	.	1	.	2	.
WISCONSIN	63	4	1	.	2	.
WYOMING	10	9	1	2	1	4
AMERICAN SAMOA	1	.	4	.	2	.
GUAM	1	2	0	0	1	1
NORTHERN MARIANAS	1	1	0	0	9	0
PALAU	0	0	0	0	0	0
VIRGIN ISLANDS	1	1	1	0	0	0
U.S. AND OUTLYING AREAS	3,418	410	734	46	933	177
50 STATES, D.C. & P.R.	3,414	406	729	46	921	177

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Table AH6

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1997

STATE	SOCIAL WORKERS		SPECIAL EDUCATORS		SPEECH AND LANGUAGE PATHOLOGISTS	
	EMPLOYED	NEEDED	EMPLOYED	NEEDED	EMPLOYED	NEEDED
ALABAMA	20	1	59	10	23	3
ALASKA	2	.	17	.	14	.
ARIZONA	23	15	44	3	37	6
ARKANSAS	19	.	174	.	174	.
CALIFORNIA	.	.	.	.	.	.
COLORADO	.	.	.	.	.	.
CONNECTICUT	12	1	129	4	66	14
DELAWARE	6	0	19	1	12	1
DISTRICT OF COLUMBIA	15	4	27	7	14	8
FLORIDA	404	.	750	.	754	.
GEORGIA	35	13	74	18	73	25
HAWAII	33	0	14	2	7	7
IDAHO	10	0	28	32	12	14
ILLINOIS	25	6	157	37	58	25
INDIANA	3	0	219	0	123	0
IOWA	18	6	77	11	27	7
KANSAS	11	1	86	7	46	5
KENTUCKY	5	.	145	.	172	.
LOUISIANA	13	4	118	27	36	9
MAINE	35	.	13	.	41	.
MARYLAND	24	1	143	1	78	1
MASSACHUSETTS	128	137	233	249	152	163
MICHIGAN	113	0	243	0	100	0
MINNESOTA	27	3	177	4	84	6
MISSISSIPPI	0	1	12	13	7	8
MISSOURI	1	.	47	.	20	.
MONTANA	2	0	2	0	6	0
NEBRASKA	3	0	87	0	40	0
NEVADA	6	0	31	6	13	0
NEW HAMPSHIRE	7	0	25	1	23	0
NEW JERSEY	31	2	75	4	51	6
NEW MEXICO	17	1	76	4	27	3
NEW YORK	843	89	1,963	127	1,357	188
NORTH CAROLINA	119	9	220	13	72	5
NORTH DAKOTA	2	0	16	0	2	0
OHIO	289	0	567	0	219	0
OKLAHOMA	1	1	33	3	38	80
OREGON	1	1	55	9	31	7
PENNSYLVANIA	37	6	305	35	165	30
PUERTO RICO	8	6	0	0	22	.
RHODE ISLAND	1	.	4	.	7	.
SOUTH CAROLINA	1	.	165	.	10	.
SOUTH DAKOTA	0	.	45	.	13	.
TENNESSEE	28	3	125	12	60	13
TEXAS	114	5	163	5	157	17
UTAH	3	2	16	4	14	2
VERMONT	2	1	16	2	8	2
VIRGINIA	43	11	53	18	67	13
WASHINGTON	20	.	85	.	95	.
WEST VIRGINIA	27	.	41	.	20	.
WISCONSIN	19	.	106	2	122	3
WYOMING	7	12	23	13	26	13
AMERICAN SAMOA	3	.	9	.	1	.
GUAM	3	4	6	7	1	2
NORTHERN MARIANAS	0	1	1	1	0	1
PALAU	0	0	2	2	0	0
VIRGIN ISLANDS	0	0	0	0	1	0
U.S. AND OUTLYING AREAS	2,621	346	7,319	692	4,797	686
50 STATES, D.C. & P.R.	2,615	341	7,301	682	4,793	683

Please see data notes for an explanation of individual State differences.
The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because (1)some States could not provide personnel data by category and (2)rounding.
Data based on the December 1, 1997 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH6

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1997

STATE	OTHER --PROFESSIONAL STAFF-- EMPLOYED	NEEDED
ALABAMA	57	7
ALASKA	26	.
ARIZONA	28	3
ARKANSAS	111	.
CALIFORNIA	.	.
COLORADO	.	.
CONNECTICUT	20	0
DELAWARE	30	1
DISTRICT OF COLUMBIA	6	3
FLORIDA	156	.
GEORGIA	8	0
HAWAII	20	4
IDAHO	36	0
ILLINOIS	60	12
INDIANA	146	0
IOWA	21	2
KANSAS	4	0
KENTUCKY	.	.
LOUISIANA	34	5
MAINE	75	.
MARYLAND	0	2
MASSACHUSETTS	61	65
MICHIGAN	87	0
MINNESOTA	25	1
MISSISSIPPI	1	2
MISSOURI	0	.
MONTANA	51	1
NEBRASKA	2	0
NEVADA	6	0
NEW HAMPSHIRE	5	0
NEW JERSEY	67	5
NEW MEXICO	30	1
NEW YORK	3	1
NORTH CAROLINA	242	11
NORTH DAKOTA	1	0
OHIO	489	0
OKLAHOMA	4	0
OREGON	28	4
PENNSYLVANIA	196	18
PUERTO RICO	15	0
RHODE ISLAND	44	.
SOUTH CAROLINA	0	.
SOUTH DAKOTA	.	.
TENNESSEE	132	8
TEXAS	489	21
UTAH	53	1
VERMONT	9	2
VIRGINIA	82	8
WASHINGTON	53	.
WEST VIRGINIA	91	.
WISCONSIN	28	.
WYOMING	11	6
AMERICAN SAMOA	4	.
GUAM	1	2
NORTHERN MARIANAS	.	0
PALAU	0	0
VIRGIN ISLANDS	0	1
U.S. AND OUTLYING AREAS	3,146	195
50 STATES, D.C. & P.R.	3,141	192

Please see data notes for an explanation of individual State differences.
The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because (1)some States could not provide personnel data by category and (2)rounding.
Data based on the December 1, 1997 count, updated as of November 1, 1999.
U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH7

Number of Infants and Toddlers Birth Through Age 2 Served in Different Early Intervention Settings Under Part C
December 1, 1997

STATE	EARLY INTERVENTION CLASSROOM	FAMILY CHILD CARE	HOME	HOSPITAL (INPATIENT)	OUTPATIENT SERVICE FACILITY
ALABAMA	758	2	489	10	319
ALASKA	18	.	332	2	6
ARIZONA	497	2	1,140	3	84
ARKANSAS	1,235	100	850	0	152
CALIFORNIA	.	.	.	.	.
COLORADO	532	11	1,174	93	331
CONNECTICUT	.	.	2,177	.	183
DELAWARE	150	6	454	4	28
DISTRICT OF COLUMBIA	264	.	25	.	26
FLORIDA	1,250	5	2,880	381	6,390
GEORGIA	402	129	1,313	2	1,217
HAWAII	495	8	2,302	4	158
IDAHO	280	1	550	2	37
ILLINOIS	3,741	79	3,467	0	29
INDIANA	1,105	27	2,128	1	846
IOWA	145	98	748	.	5
KANSAS	307	59	1,078	1	124
KENTUCKY	.	.	.	.	.
LOUISIANA	118	17	1,173	2	350
MAINE	19	20	207	99	187
MARYLAND	1,240	53	2,344	1	135
MASSACHUSETTS	.	.	9,645	.	.
MICHIGAN	1,311	13	3,772	47	165
MINNESOTA	622	.	1,903	8	66
MISSISSIPPI	0	70	1,816	1,135	453
MISSOURI	516	8	1,021	17	168
MONTANA	3	7	490	1	4
NEBRASKA	180	1	612	4	4
NEVADA	664	2	256	5	0
NEW HAMPSHIRE	40	3	798	0	0
NEW JERSEY	1,441	33	1,871	24	439
NEW MEXICO	442	2	1,149	3	36
NEW YORK	5,182	91	11,848	66	151
NORTH CAROLINA	420	190	3,439	0	0
NORTH DAKOTA	0	1	317	0	5
OHIO	877	16	1,649	31	185
OKLAHOMA	33	15	1,697	4	51
OREGON	459	11	759	2	67
PENNSYLVANIA	1,278	25	4,678	43	235
PUERTO RICO	.	.	.	.	4,773
RHODE ISLAND	230	5	350	46	43
SOUTH CAROLINA	57	4	1,275	3	659
SOUTH DAKOTA	160	24	222	6	37
TENNESSEE	808	21	1,350	14	1,062
TEXAS	108	299	10,044	3	167
UTAH	744	19	1,168	0	0
VERMONT	.	13	238	.	9
VIRGINIA	450	33	1,171	9	702
WASHINGTON	1,272	18	728	32	333
WEST VIRGINIA	592	0	1,252	3	13
WISCONSIN	1,698	23	1,711	23	343
WYOMING	114	16	231	1	7
AMERICAN SAMOA	42	.	6	0	0
GUAM	64	0	158	0	0
NORTHERN MARIANAS	21	0	22	0	0
PALAU	0	0	9	0	0
VIRGIN ISLANDS	8	5	34	0	12
U.S. AND OUTLYING AREAS	32,392	1,585	92,520	2,135	20,796
50 STATES, D.C. & P.R.	32,257	1,580	92,291	2,135	20,784

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1997 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

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Table AH7

Number of Infants and Toddlers Birth Through Age 2 Served in Different Early Intervention Settings Under Part C
December 1, 1997

STATE	REGULAR NURSERY SCHOOL/ CHILD CARE	RESIDENTIAL FACILITY	OTHER SETTING	ALL SETTINGS
ALABAMA	2	1	4	1,585
ALASKA	1	1	6	366
ARIZONA	1	0	25	1,752
ARKANSAS	9	2	0	2,348
CALIFORNIA	.	.	.	.
COLORADO	45	1	148	2,335
CONNECTICUT	505	.	.	2,865
DELAWARE	13	2	190	847
DISTRICT OF COLUMBIA	1	.	.	316
FLORIDA	39	12	309	11,266
GEORGIA	273	2	34	3,372
HAWAII	17	0	151	3,135
IDAHO	10	0	23	903
ILLINOIS	58	0	385	7,759
INDIANA	97	3	578	4,785
IOWA	50	1	51	1,098
KANSAS	59	0	21	1,649
KENTUCKY	.	.	.	.
LOUISIANA	27	3	73	1,763
MAINE	64	2	.	598
MARYLAND	48	2	14	3,837
MASSACHUSETTS	.	.	.	9,645
MICHIGAN	13	5	271	5,597
MINNESOTA	207	.	.	2,806
MISSISSIPPI	230	0	0	3,704
MISSOURI	55	1	381	2,167
MONTANA	8	0	18	531
NEBRASKA	2	4	4	811
NEVADA	15	2	0	944
NEW HAMPSHIRE	8	0	0	849
NEW JERSEY	126	10	68	4,012
NEW MEXICO	22	4	13	1,671
NEW YORK	492	16	104	17,950
NORTH CAROLINA	879	0	24	4,952
NORTH DAKOTA	3	0	0	326
OHIO	11	0	46	2,815
OKLAHOMA	31	3	95	1,929
OREGON	128	1	10	1,437
PENNSYLVANIA	124	11	550	6,944
PUERTO RICO	.	.	.	4,773
RHODE ISLAND	99	0	83	856
SOUTH CAROLINA	2	0	20	2,020
SOUTH DAKOTA	16	3	14	482
TENNESSEE	35	1	43	3,334
TEXAS	1,123	22	95	11,861
UTAH	0	0	3	1,934
VERMONT	49	.	15	324
VIRGINIA	4	6	6	2,381
WASHINGTON	56	3	20	2,462
WEST VIRGINIA	2	0	13	1,875
WISCONSIN	77	0	12	3,887
WYOMING	31	0	5	405
AMERICAN SAMOA	0	0	0	48
GUAM	9	0	0	231
NORTHERN MARIANAS	0	0	0	43
PALAU	0	0	0	9
VIRGIN ISLANDS	6	2	0	67
U.S. AND OUTLYING AREAS	5,182	126	3,925	158,661
50 STATES, D.C. & P.R.	5,167	124	3,925	158,263

Please see data notes for an explanation of individual State differences.

Data based on the December 1, 1997 count, updated as of November 1, 1999.

U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Notes for Appendix A

Notes to the profile tables contain information on the ways in which States collected and reported data differently from the OSEP data formats and instructions. In addition, the notes provide explanations of significant changes in the data from the previous year. The chart below summarizes differences in collecting and reporting data for 13 States. These variations affected the way data were reported for the IDEA, Part B child count, the educational environment, and exiting collections. Additional notes on how States reported data for specific data collections follow this chart.

Table A-1
State Reporting Patterns for IDEA, Part B Child Count Data 1998-99, Other Data 1997-98

States	Differences from OSEP Reporting Categories Where H = Reported in the hearing impairments category O = Reported in the orthopedic impairments category P = Reported in the primary disability category R = Reported in other disability categories Multiple Disabilities	Other Health Impairments	Deaf-Blindness	Traumatic Brain Injury
Colorado		O		
Delaware	P	O		
Florida	P			
Georgia	P			
Illinois	P			
Michigan		O	H	R
Minnesota	P			
Mississippi		O		
North Dakota	P			
Oregon	P			
West Virginia	P			
Wisconsin	P			
Wyoming	P			

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Tables AA1 – AA18: Child Count

NOTE: Twelve States suggested the increases in their counts of students with other health impairments were due to increases in the identification and inclusion of students with attention deficit disorder and attention deficit hyperactivity disorders. These States include:

Alabama	Georgia	Missouri	Virginia
Arizona	Kentucky	Nevada	West Virginia
Arkansas	Maryland	Rhode Island	Wisconsin

Ten States commented that the increases in counts of students with autism were a result of better diagnosis and identification of the disorder, continued reclassification of students, and improved training in methods and assessments of autism. These States include:

Arizona	Georgia	Missouri	Wisconsin
California	Indiana	New Jersey	
Connecticut	Maryland	Ohio	

Alabama -- The State attributed the increase from 1997-98 to 1998-99 in the number of students with developmental delay to a greater utilization of this category. In 1997-98, not all eligible children were reported in this category.

Hawaii -- The State thought that the increases from 1997-98 to 1998-99 in the number of students with emotional disturbance and other health impairments were a result of increased public awareness. Hawaii has been under the Felix Consent Decree since 1994, and the publicity associated with the court intervention has resulted in an increase in referrals.

New Jersey -- The State indicated that the large increase from 1997-98 to 1998-99 in the number of students with traumatic brain injury (TBI) was due to a change in State regulations redefining the old State category "neurologically impaired" exclusively as the Federal category TBI. This categorical change also affected the number of students reported in the specific learning disability category. In the past, the previous combination of "neurologically impaired" and "perceptually impaired" was reported under the Federal "specific learning disability" category. Most of the neurologically impaired pupils will be reevaluated and classified under specific learning disability, communication impairments, some other category, or declassified as not eligible for special education. New Jersey anticipates that over the next 2-3 years, the TBI figures will drop dramatically and that other categories will increase concomitantly.

On October 25, 1999, OSEP decided that New Jersey's decision to grandfather in students with neurological impairments into the TBI category until they are reevaluated seriously distorts New Jersey's and the nation's distribution of students by disability. This decision is reinforced by the State's belief that the actual number of students with

TBI is under 100. Therefore, New Jersey's 1998-99 child count and race/ethnicity figures for TBI and SLD were adjusted using regression techniques.

New Mexico -- The State attributed the decrease from 1997-98 to 1998-99 in the number of children served with developmental delay to the expiration of a 1-year pilot program to extend developmental delay eligibility through age 9. The program was not authorized in 1998-99, but will be in subsequent years.

New York -- The State noted that 17,337 of the 48,892 age 3- through 5-year-old children reported were considered school aged; consequently, their race/ethnicity data were included with the data for students ages 6 through 21. Hence, the race/ethnicity data for both age groups do not equal the age year data.

Virginia -- The State indicated that the decrease from 1997-98 to 1998-99 in the number of students with multiple disabilities was due to the first-time separate reporting of students with developmental delay who had previously been reported in the multiple disabilities category.

Tables AB1 - AB8: Educational Environments

Alabama -- The State indicated that the decrease from 1996-97 to 1997-98 in the number of students served in parent-initiated private school placement was a result of the 1997 amendments to IDEA. There was a change in the method whereby local school districts deliver services to students with disabilities in parent-initiated private schools which eliminated services to many of these students.

Illinois -- The State indicated that the decrease from 1996-97 to 1997-98 in homebound/hospital environments was to correct a reporting error that occurred over the past several years. Illinois also noted that some of its definitions regarding least restrictive environment do not match the Federal definitions. For example, those students who are reported as being in resource rooms may be receiving services in the resource room from 1 percent up to 49 percent of the school day. Additionally, the count for students in separate classes includes students receiving special education and related services for 50 percent or more of the school day.

Iowa -- The State attributed the increase from 1996-97 to 1997-98 in resource room placements to a change from reporting based on a study to reporting based on actual data on each student.

Mississippi -- The State indicated that the data reported in the other health impairments category represent data on students with developmental delay. As noted in table A-1, Mississippi reported data on students with other health impairments in the orthopedic impairments category.

Missouri -- The State attributed the decrease from 1996-97 to 1997-98 in the number of parent-initiated private school placements to the difficulty districts experience collecting this information from private/parochial schools. Missouri attributed the increase in private residential facility placements and the decrease in public residential facility placements from 1996-97 to 1997-98 to increased contracting with private agencies. The State attributed the increase from 1996-97 to 1997-98 in resource room placements to the full participation of all 525 districts in the collection. Approximately 6 percent of the districts were unable to report data the previous year.

New York -- The State indicated that the decrease from 1996-97 to 1997-98 in public separate school facility was due to efforts to move students away from more restricted settings. New York indicated that the decrease from 1996-97 to 1997-98 in correctional facilities was a result of budgetary problems at the Department of Corrections. The Department is in the process of rebuilding its program.

Puerto Rico -- The State indicated that the decrease from 1996-97 to 1997-98 in homebound/hospital placements was a result of serving some of these students in less restrictive environments. Puerto Rico noted that the increase from 1996-97 to 1997-98 in parent-initiated private school placements was supported by an analysis conducted by its Department of Special Education.

South Dakota -- The State indicated that the increase from 1996-97 to 1997-98 in the number of students reported in correctional settings was due to increased child identification efforts by the Department of Corrections. The Department of Corrections has also paid more attention to its reporting requirements under IDEA.

Texas -- State law mandated a change in the collection of data in several environments (Texas Education Code 42.151). Texas noted that the following environments--self-contained, separate campus; multi-district class; and community class--were collapsed into one "off home campus" environment. These students are now all reported under public separate facility. This has resulted in a slight decrease for separate class placements.

Tables AC1 – AC3: Personnel

Alabama -- The State attributed the decrease from 1996-97 to 1997-98 in total demand for counselors to the greater availability of counselors among general education students. Alabama thought that the increase from 1996-97 to 1997-98 in teacher aides was a direct result of more students being served in regular class environments.

Arizona -- The State attributed the changes from 1996-97 to 1997-98 in personnel data to changes in staff during the collection period and to improper completion of the forms at the local level. During the data collection, there were no personnel at the State level to monitor the data collection and ensure data quality and integrity. The State anticipates that the 1998-99 data will be more accurate.

California -- The State attributed the changes from 1996-97 to 1997-98 in the various personnel categories to the following factors: (1) California's total enrollment increases by about 20,000 students per year; (2) personnel numbers fluctuate as personnel get reclassified due to changes in job titles and duties; and (3) California has mandated class size reductions for the first three grades.

Georgia -- The State indicated that the decrease from 1996-97 to 1997-98 in the total demand for counselors was due to the correction of erroneous reporting by three large school districts in the previous year. These districts had reported counts of all their counselors rather than only the FTE of counselors that provided special education. Georgia indicated that the increase from 1996-97 to 1997-98 in the total demand for speech pathologists was due to districts reporting all speech personnel in this category whereas in previous years, districts reported speech personnel under both teachers and other personnel.

Illinois -- The State indicated that the increase from 1996-97 to 1997-98 in not fully certified school social workers was due to the approval of additional school social work internships during 1997-98 (i.e., more students were completing educational program requirements).

Kentucky -- The State attributed the increase from 1996-97 to 1997-98 in the number of speech pathologists employed but not fully certified to a State policy, instituted a couple of years ago, that allowed speech pathologists with 4-year certificates to work under fully certified pathologists.

Maine -- The State indicated that the differences in the personnel data from 1996-97 to 1997-98 were a result of the 1997-98 figures including public, private, and preschool data, whereas the 1996-97 and 1995-96 figures included only public school data. The preschool data are not available for the prior years, but Maine will submit revised figures that include the private school data.

Missouri -- The State attributed the increase from 1996-97 to 1997-98 in the number of employed, not fully certified teachers to an increase in the child count and the greater use of teachers with provisional certificates. Missouri attributed the increase in the demand for teacher aides to a growth in the use of inclusive practices and better retention of staff.

New Jersey -- The State attributed the differences from 1996-97 to 1997-98 in the personnel data to difficulties in recordkeeping at the district level, particularly for part-time contracted staff.

New Mexico -- The State indicated that the increase from 1996-97 to 1997-98 in counselors and diagnostic staff was due to the increased funding available at the State level for these personnel. The State funding formula included for the first time full funding of diagnostic FTE. There was partial funding available in 1996-97, and no funding previous to that. Another factor that contributed to the growth in counselors

was increased attention to the behavioral/mental health needs of students, particularly from advocates, school personnel, and the legal system. New Mexico indicated that the decrease from 1996-97 to 1997-98 in the number of vacant positions for speech pathologists was a result of a change in the State funding formula, i.e., not funding of vacant positions. As of December 1997, districts were not allowed to report data on vacant positions.

New York -- The State verified the changes from 1996-97 to 1997-98 in physical education teachers, psychologists, teacher aides, diagnostic and evaluation staff, counselors, other professional staff, and interpreters. New York indicated that there was an error in its data collection form that resulted in data not being collected on vacant occupational therapy positions for school-age children. Data on vacant occupational therapy positions were only collected for preschool children. The State thought that the increase in supervisors/administrators was due to an error in reporting by one district.

North Carolina -- The State attributed the overall increase from 1996-97 to 1997-98 in personnel to the addition of new charter schools (100 charter schools were approved by the legislature). North Carolina indicated that the increase from 1996-97 to 1997-98 in non-professional staff was a result of State funding to assist with the inclusion of students in regular classrooms.

Pennsylvania -- The State indicated that the increase from 1996-97 to 1997-98 in the demand for speech pathologists was due to the following factors. An intensive training program for speech pathologists has added to the pool of available certified staff, and figures for speech pathologists are subject to considerable variation as only speech pathologists who serve children whose primary disability is a speech impairment are counted. Pennsylvania verified the decrease from 1996-97 to 1997-98 in demand for non-professional staff.

Puerto Rico -- The State attributed the decrease from 1996-97 to 1997-98 in the demand for non-professional staff to the reclassification of childcare attendants from non-professional staff to teacher aides. Puerto Rico thought they were better reported as teacher aides as they provided direct services to students. Non-professional staff includes personnel such as data entry personnel and bus drivers.

Texas -- The State attributed the changes in personnel from 1996-97 to 1997-98 to a decision to report all personnel under fully certified when certification is not maintained through the State Board of Education Certification (SBEC). This is in contrast to previous reporting practices. Texas noted that there were also some increases in the data due to growth in the program.

Virginia -- The State verified the changes from 1996-97 to 1997-98 in vocational education teachers, work-study coordinators, teacher aides, and total personnel. Changes were due to more accurate reporting.

Washington -- The State attributed the changes from 1996-97 to 1997-98 in demand for interpreters, occupational therapists, and school social workers to a change in its data collection process. The State used a different data collection process for its December 1, 1996 collection; this process proved unsatisfactory, so Washington returned to its original process for the December 1, 1997 collection.

Tables AD1 – AD7: Exiting

Arizona -- The State thought that the decrease from 1996-97 to 1997-98 in the number of students who dropped out was attributable to the greater involvement of school staff, parents, and other stakeholders in meeting the needs of children.

Colorado -- The State verified the increase from 1996-97 to 1997-98 in number of students who returned to regular education and the decrease from 1996-97 to 1997-98 in the number of students who moved and were not known to be continuing. Colorado noted that the 1996-97 data report included only children who returned to regular education with objectives accomplished, whereas the 1997-98 report also included those children who were withdrawn from special education by their parents and those who were receiving home-based instruction.

Connecticut -- The State attributed the increase from 1996-97 to 1997-98 in the total number of students who exited special education to improved data collection techniques.

Georgia -- The State indicated that the increase from 1996-97 to 1997-98 in the number of students who moved and were known to be continuing was due to a statewide increase in the number of students who move between communities because of family or other reasons.

Mississippi -- The State verified the decrease from 1996-97 to 1997-98 in the number of students with specific learning disabilities exiting school with a certificate.

Missouri -- The State attributed the changes from 1996-97 to 1997-98 in the exiting data to the full participation of all 525 districts in the collection. Approximately 6 percent of the districts were unable to report data the previous year.

New Jersey -- The State attributed the changes from 1996-97 to 1997-98 in the number of students who graduated and in the total number of students who exited to an increase in the number of students with specific learning disabilities who graduated with a high school diploma.

New York -- The State attributed the increase from 1996-97 to 1997-98 in the number of students who moved and were not known to be continuing to more districts reporting data in this category. For example, New York City and the Department of Corrections reported these data for the first time in 1997-98.

Texas -- The State attributed the increases from 1996-97 to 1997-98 in the number of students exiting to improvements in reporting. Additionally, some categories are being reported for the first time.

Washington -- The State attributed the increase from 1996-97 to 1997-98 in the total number of students who graduated with a diploma or died to improvements in the tracking and reporting of exiting students.

Table AH1: Counts of Infants and Toddlers Served

Illinois -- The State thought that the decrease from 1997-98 to 1998-99 in the number of infants and toddlers served under Part C may be a result of the recent change in lead agency from Education to Health. Illinois noted that the figures represent an unduplicated count of infants served. The State thought that next year's figures might be higher due to a recent change in eligibility criteria.

Kentucky -- The State attributed the increase from 1997-98 to 1998-99 in the number of infants and toddlers to using a more accurate count and to growth in the system. Kentucky changed from a manual collection in 1997 to an electronic collection in 1998, a Central Billing and Information System (CBIS).

New Mexico -- The State attributed the decrease from 1997-98 to 1998-99 in the number of infants served to a change in reporting methodology that accompanied the implementation of a new data system. Data reported in previous years included all infants in the system, whereas the current data include only infants with IFSPs. New Mexico further noted that some of the decrease was due to the less than full implementation of the new data system, namely, a few children still remain to be entered into the system.

Ohio -- The State indicated that the decrease from 1997-98 to 1998-99 in child count was due to Ohio's implementation of a new statewide data collection system (Early Track) designed to provide more accurate and reliable data. Ohio anticipates that there will be an improvement in the data as the new system is more fully implemented.

South Dakota -- The State indicated that the increase from 1997-98 to 1998-99 in the number of infants identified is accurate and reflects a major increase in child find.

Texas -- The State indicated that race/ethnicity data were not available for some children who were enrolled prior to the implementation of race/ethnicity data requirements on September 1, 1998.

Table AH5: Early Intervention Services

Arkansas -- The State attributed the increase from 1996-97 to 1997-98 in audiology services to its decision to report all hearing screenings in this category. Arkansas attributed the increase in family training, counseling, and home visits and the decrease in other early intervention services to its decision to combine all special instruction services under the family training category so infants can receive all their services in one visit. Many of the children reported in 1996-97 in the other early intervention services category were reported in 1997-98 in the family training category.

Colorado -- The State indicated that the decrease from 1996-97 to 1997-98 in other early intervention services was due primarily to better data and an improved ability to correctly categorize service, thereby resulting in a movement from other early intervention services to special instruction and respite care. Colorado noted that an additional reason for the increase in respite care and special instruction was the overall increase in services reported.

Connecticut -- The State attributed the reduction fron. 1996-97 to 1997-98 in family training, counseling, and home visits to a decision to report only counseling in this category. The State attributed the increase from 1996-97 to 1997-98 in special instruction and speech language pathology to its decision to move toward a more restrictive use of the family training, counseling, and home visits category.

Delaware -- The State attributed the decrease from 1996-97 to 1997-98 in nursing services to the State's emphasis on family training. Nurses are now utilized in Part C as service coordinators and work closely with families to provide training on effective interventions that parents can carry out in natural environments. The change in service levels is a reflection of Delaware's movement toward an integrated and family-friendly service delivery model.

Illinois -- The State indicated that the decrease from 1996-97 to 1997-98 in the number of children who received nursing services was a result of using a clearer and more restrictive definition of nursing services.

Indiana -- The State indicated that it could not comment on the data changes from 1996-97 to 1997-98 for the following reason. Indiana began the transition to a central data and claims payment system in July 1996; in August 1997, all counties were on line. One complete year of data did not become available until August 1, 1998. During the transition period, the State had to manually combine data from summary reports submitted by counties which were not on the system and detailed data from counties which were on the system. The reliability and validity of these combined data are suspect since they could not be matched against the central system for duplication and because the transition data were occasionally gathered by personnel who had less experience in gathering the data than former local lead agencies.

Kentucky -- The State attributed the increase in medical services from 1996-97 to 1997-98 to a combination of low reporting in 1996-97, more accurate reporting in 1997-98, and an increasing population. Kentucky noted that in 1996-97 it was still in a grant-based system that presented difficulties in determining actual services, even though the child count was fairly accurate. In 1997-98, the State began using a fee system that provides the actual number of evaluations. Kentucky said that the same was true for the increase from 1996-97 to 1997-98 in the specialized therapies. It is better able to report actual events of service, and the population has continued to dramatically increase.

Michigan -- The State thought the increase in health services and nursing services from 1996-97 to 1997-98 was a result of the lead agency working with providers to more accurately report data in specific service categories rather than combining them in the other category.

Missouri -- The State attributed the increase from 1996-97 to 1997-98 in transportation services to its continuing emphasis on the accuracy of the data supplied by the collaborating departments. Additionally, OSEP monitoring has resulted in the State providing better training on the determination of need for transportation.

Nebraska -- The State indicated that the increase from 1996-97 to 1997-98 in the number of children who received special instruction services was due to a change in the State's interpretation of the category.

Nevada -- The State attributed the changes from 1996-97 to 1997-98 in the number of children who received various services to varying perceptions of the definitions of services across providers. In particular, it appears that providers were alternating the reporting of some services between the medical services and the other early intervention services categories. The State is making an effort to clarify the definitions and make them consistent with OSEP's. Nevada also thought that the increase from 1996-97 to 1997-98 in the number of children who received assistive technology services was a result of adding this service to the IFSP.

New York -- The State attributed the decrease from 1996-97 to 1997-98 in the number of infants who received audiology services to discontinuing the practice of including audiological evaluations in the figures. New York stated that the increase from 1996-97 to 1997-98 in the number of infants who received respite care was a result of recent efforts by the Department of Health to encourage local administrators to promote access to these services. In addition, the Department of Health issued a new parent handbook that has educated parents to the availability of respite services.

North Carolina -- The State attributed the changes from 1996-97 to 1997-98 in reported services and transportation services to the full participation of private providers in the Part C process and to the availability of vouchers and subsidies to complement the traditional approaches to securing services.

Ohio -- The State thought the decrease from 1996-97 to 1997-98 in number of children who received services was a result of the implementation of a new statewide data system. Ohio indicated that at the time of reporting, several counties were not included in the statewide count due to delayed participation and/or lack of full participation. The State further indicated that it anticipates that these figures will rise in the following years.

Texas -- The State attributed the decrease from 1996-97 to 1997-98 in the number of children who received family training, counseling, and home visits to the introduction of a policy requiring services to be provided in natural environments. Before this policy, home visits were considered a separate or augmented service. After the policy, home visits were classified according to the service(s) provided. The State indicated that the decrease from 1996-97 to 1997-98 in the number of children who received transportation services was due to the introduction of the natural environments policy; transportation needs decreased since greater efforts were made to deliver services to the family.

Utah -- The State attributed the decrease from 1996-97 to 1997-98 in nursing services to the discontinuation of services by a provider who used nurses to provide family training/counseling services.

Washington -- The State attributed the decrease from 1996-97 to 1997-98 in the number of children who received other early intervention services to a clarification of reporting procedures to exclude reporting service coordination in this category as was done in previous years.

Table AH6: Early Intervention Personnel Employed and Needed

Arkansas -- The State thought that the increase from 1996-97 to 1997-98 in employed personnel was due to its recruitment efforts which have resulted in an expansion of the provider pool.

California -- The State indicated that it has no reliable method of collecting personnel data and hence will not submit any.

Delaware -- The State attributed the decrease in nurses from 1996-97 to 1997-98 to a change in its counting methodology. Many of the nurses reported in December 1, 1996 were employed in primary care physician offices. Typically, these nurses did not provide early intervention services, but rather provided medical health services. Beginning in 1997, nurses in primary care physician offices who did not provide early intervention were not counted. Furthermore, more nurses were employed as Part C service coordinators by the State, which resulted in a reduction in the need for nurses to provide direct nursing services.

Illinois -- The State suspects that the decrease from 1996-97 to 1997-98 in other professional staff was a result of its efforts to tighten eligibility requirements and improve reporting in preparation for a change in lead agencies.

Indiana -- The State indicated that it could not comment on the data changes for the following reason. Indiana began the transition to a central data and claims payment system in July 1996; in August 1997, all counties were on line. One complete year of data did not become available until August 1, 1998. During the transition period, the State had to manually combine data from summary reports submitted by counties which were not on the system and detailed data from counties which were on the system. The reliability and validity of these combined data are suspect since they could not be matched against the central system for duplication and because the transition data were occasionally gathered by personnel who had less experience in gathering the data than former local lead agencies.

Kentucky -- The State attributed the increase from 1996-97 to 1997-98 in personnel to a combination of more accurate reporting and an overall increase in the population.

Maine -- The State attributed the increase from 1996-97 to 1997-98 in total personnel employed to a growth in the number of personnel employed to provide services to infants in natural settings.

Massachusetts -- The State verified the increase from 1996-97 to 1997-98 in the number of speech/language pathologists employed and the decrease from 1996-97 to 1997-98 in the number of other professional staff employed. Massachusetts indicated that the figures reflect actual personnel data as submitted by providers. The State believes the increase from 1996-97 to 1997-98 in speech/language personnel was a result of the rapid growth in the number of children with speech and language delays. Massachusetts suspects that the increase from 1996-97 to 1997-98 in speech/language personnel may have contributed to the decrease from 1996-97 to 1997-98 in other professional staff.

Ohio -- The State attributed the increase from 1996-97 to 1997-98 in personnel to improved reporting as a result of the implementation of a new data system.

South Dakota -- The State indicated that the increase from 1996-97 to 1997-98 in the number of special educators was accurate and coincided with a major increase in the number of children identified.

Texas -- The State attributed the decrease from 1996-97 to 1997-98 in the number of paraprofessionals employed to a preference toward hiring more professional and fully qualified or degreed individuals.

Washington -- The State attributed the increases from 1996-97 to 1997-98 in physical therapists, speech language pathologists, other professional staff, and total staff to increased data quality as a result of the increased technical assistance that has been provided to contractors over the past 2 years.

Table AH7: Early Intervention Service Settings

Arkansas -- The State provided the following explanations for changes in the settings data from 1996-97 to 1997-98. (1) The increase from 1996-97 to 1997-98 in family child care was due to efforts to provide more services in the natural environment of the child. (2) The decrease from 1996-97 to 1997-98 in outpatient service facilities was due to an increase from 1996-97 to 1997-98 in service providers who provide services in the natural environment. (3) The increase from 1996-97 to 1997-98 in early intervention classroom/centers and the decrease from 1996-97 to 1997-98 in regular nursery school/child care centers were due to a change in certification status of some providers to early intervention classroom/center.

Colorado -- The State attributed the decrease from 1996-97 to 1997-98 in other settings to better data and improvements in its ability to correctly categorize location, thereby resulting in a movement from other settings to home and early intervention classroom/center. Colorado further noted that there has been an effort to provide more services in the home. This was particularly true for children who did not receive direct hands-on therapy; the State has made an effort to provide case management and family support services primarily in the home.

Connecticut -- The State attributed the reduction from 1996-97 to 1997-98 in number of children receiving services in an outpatient service facility to its continued work toward delivering services in natural environments.

Delaware -- The State attributed the decrease from 1996-97 to 1997-98 in outpatient service facilities and the increase from 1996-97 to 1997-98 in other settings to its emphasis on increasing service provision in natural environments.

Illinois -- The State attributed the increase from 1996-97 to 1997-98 in family child care settings to its efforts to serve children in more natural settings.

Indiana -- The State indicated that it could not comment on the data changes for the following reason. Indiana began the transition to a central data and claims payment system in July 1996; in August 1997, all counties were on line. One complete year of data did not become available until August 1, 1998. During the transition period, the State had to manually combine data from summary reports submitted by counties which were not on the system and detailed data from counties which were on the system. The reliability and validity of these combined data are suspect since they could not be matched against the central system for duplication and because the transition data were occasionally gathered by personnel who had less experience in gathering the data than former local lead agencies.

Iowa -- The State attributed the increase from 1996-97 to 1997-98 in family child care to the following factors: (1) emphasis on serving children in natural environments and (2) more families in the workplace. Iowa has one of the highest rates of working

mothers of children under 5 in the nation; as a rural State, most of these mothers have access to extended family members living close by to provide child care.

Kentucky -- The State indicated that settings data are collected through its billing system which only recognizes two categories--"home or community based" and "office or center based"--hence it is unable to provide data in the requested format.

Michigan -- The decrease from 1996-97 to 1997-98 in outpatient service facility settings was due to one service provider deciding to report infants who received both outpatient and home services in the home category.

Missouri -- The State attributed the increase from 1996-97 to 1997-98 in other settings to its continuing emphasis on the accuracy of the data supplied by the collaborating departments.

New Jersey -- The State attributed the decrease from 1996-97 to 1997-98 in early intervention classroom/center settings and the increase from 1996-97 to 1997-98 in home settings to a shift to natural environments. New Jersey thought the decrease from 1996-97 to 1997-98 in other settings was a result of clarifying definitions of location and fewer children reported as receiving service coordination only.

New York -- The State attributed the increase from 1996-97 to 1997-98 in home settings to an emphasis by local administrators on providing services in the natural environment. New York attributed the increase from 1996-97 to 1997-98 in regular nursery school/child care settings to efforts by the Department of Health to ensure that the child care community was aware of the early intervention program and that eligible children were able to receive services in their current child care setting when appropriate.

Texas -- The State thought the decreases from 1996-97 to 1997-98 in early intervention classroom/center and the increase in regular nursery school/child care centers were the result of the incorporation of its natural environments policy. Since the policy was implemented, very few children receive classroom or center-based services. Similarly, more children now receive services where they would typically spend their day.

Washington -- The State attributed the increase from 1996-97 to 1997-98 in the number of children served in outpatient service facilities to the growing prevalence of managed care providers as sources of funding. Many of these providers will only pay for services if they are provided in clinical settings. Part C as the payer of last resort can only be accessed after all the other sources. The State is trying to align the inconsistencies that exist between serving children in natural environments and Part C being the payer of last resort.

APPENDIX B

ACTIVITIES OF THE REGIONAL RESOURCE CENTERS

The Regional Resource and Federal Center Program assists State education agencies (SEAs) in building their capacity to improve services for infants, toddlers, children, and youth with disabilities. The role of the six Regional Resource Centers (RRCs) is to provide advice and technical assistance to administrators and educators in SEAs, local education agencies, and other appropriate public agencies. Information related to the activities conducted by the RRCs is included in each Annual Report.

Regional Resource and Federal Center Network

The Office of Special Education Programs (OSEP) provides assistance to States implementing the Individuals with Disabilities Education Act (IDEA) through its Regional Resource and Federal Center (RRFC) Network. This national program of technical assistance and information dissemination is designed to help State education agencies (SEAs) improve their systems of early intervention, special education, and transition services through the development and implementation of policies, programs, and practices focused on enhancing educational results for children and youth with disabilities. The Network is composed of six Regional Resource Centers (RRCs) and the Federal Resource Center (FRC). The six RRCs have been funded to help States clarify and respond to emerging issues; to provide information on research-based practices to address those issues; and to provide consultation, planning, and other technical assistance to support States on those issues. The FRC supports RRC work in States by coordinating information and activities across regions and by serving as a key connection with other technical assistance and dissemination projects funded by OSEP.

The emphasis in the reauthorization of IDEA was on the system--on effecting positive outcomes for children with disabilities through accountable programs. Close connections between the RRCs and States, and between the RRFC Network and OSEP, with its array of programs, inform and support the critical interplay among Federal initiatives and regional structures to promote local effects. A recent highlight of this effective collaboration has been the Network's support of OSEP's leadership in its Continuous Improvement Monitoring Process. RRC Network services may be characterized as (1) coordinated regional responses and (2) collaborative nationwide responses.

Coordinated Regional Responses to States

Beyond working with OSEP staff, SEAs view the RRCs as their primary source of assistance. Soon after the IDEA Amendments of 1997 were enacted, States sought RRC assistance in making changes in policies, procedures, formats, and systems that would help them come into compliance and improve performance for all children. States turn to the Network to provide them with the best available information and technical assistance and are often interested in benefiting from other States' experiences and practices. RRC assistance capitalizes on Network capacity to ensure a cohesive approach, consistent nationwide access to the best available practice, and a comprehensive response to States in their implementation of requirements for OSEP and SEA monitoring. The RRCs have responded to hundreds of requests for

information, convened regional workgroups, provided numerous consultation and training events, and facilitated meetings and work groups in specific States region-wide and at the national level. RRCs have designed information modules, web pages, and other up-to-date, accessible resources to support States involved in OSEP's Continuous Improvement Monitoring Process and in the redesign of their own monitoring systems. Maintaining currency and quality across the Network, the RRCs collaborate with each other and with other Department of Education and OSEP-funded projects to make timely and effective information available to all States.

Collaborative Nationwide Responses

The primary coordinating body for RRC monitoring efforts nationwide is the RRFC Monitoring Work Group, which includes representatives from each of the RRCs, the FRC, the National Early Childhood Technical Assistance System (NECTAS), the National Association of State Directors of Special Education (NASDSE), and OSEP. This work group coordinates and links; as issues arise in one region, that RRC brings them to the work group to gather ideas and information on strategies that may have been tried with other States and in other regions. The RRC-NECTAS connection ensures that the common issues and strategies for Parts C and B are kept visible across States and modeled through cooperative ventures of the two technical assistance systems. RRCs keep each other informed of activities in their regions that might be accessed by States in other regions. The work group also provides a timely vehicle whereby OSEP and NASDSE representatives can alert RRCs and, through them, their States to national activities and emerging issues.

This group provides the impetus and guidance for the National Monitoring Conference, intended for individuals involved in supervising, designing, or implementing monitoring programs under Parts B and C of IDEA. With reauthorization came increased expectations in accountability and results; high stakes assessments, graduation and curriculum standards, and other accountability indices drive accreditation and funding. There are also increased expectations for collaboration between State and local service providers, across Part C, Section 619, and school-aged Part B, and between higher education and State departments in their State improvement plans and grants. These all contribute to the importance of the national conference, where State staff, technical assistance providers, parents, and others hear nationally recognized experts and State practitioners present effective practices and engage in networking and facilitated discussions of common issues. The 1999 conference included over 230 participants from all 50 States, in sessions focused on how States are planning for and meeting increased expectations in accountability and results with data systems that are keyed to discipline, standards, and student outcomes. Sessions also focused on how States are developing comprehensive and effective systems that ensure both compliance with the letter of the law and with the quality intents of the law.

State monitoring developments and practices are informed and supported routinely through a variety of Network strategies:

- A collaborative listserv enables individual Centers to request information from every other region and to convey consolidated information to a State in need of immediate response;
- Information modules, regionally designed but nationally available, address specific issues in monitoring raised by one or more States;
- A national profile helps RRCs respond to State questions about other States' practices;
- The National State Policy Database provides a single site for collecting, accessing, and researching State policies nationwide (launched by NASDSE's Project FORUM, the database is now housed at the Great Lakes RRC); and
- The recently created National Monitoring and Promising Practices web site offers an important national information resource for highlighting effective monitoring practices (an OSEP initiative, the Mountain Plains RRC led the design team composed of staff from OSEP, RRC, NECTAS, and NASDSE).

RRC partnerships with OSEP, NECTAS, NASDSE, and other technical assistance and development programs unify and strengthen assistance to States improving their monitoring systems, in turn improving outcomes for children. These partnerships also model for States how collaboration among agencies yields long-term and effective results.

The enduring alliance among OSEP, the SEAs, and the RRCs demonstrates critical interactions of Federal, State, and local policy and resources which affect local practices. OSEP's Continuous Improvement Monitoring System has renewed partnerships in Federal, State, and local arenas; increased stakeholder involvement; enhanced Federal compliance monitoring; and raised expectations nationally for achieving positive results for students with disabilities. RRCs are often integrally involved in OSEP monitoring visits, assisting State leadership in the self-assessment and planning processes, designating and including critical stakeholders, etc. RRCs have worked with OSEP in its effort to refine its own monitoring process: conducting consumer satisfaction interviews with State staff during the pilot year, providing input on the Monitoring Manual, and most recently creating with OSEP and technical assistance and development colleagues the National Monitoring and Promising Practices website. The RRFC Network, its activities, and partnerships continue to help States make improvements in their monitoring systems and

procedures which support their compliance with IDEA and promote change leading to improved results for children and youth with disabilities.

CONNECTING PEOPLE & KNOWLEDGE
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